

Substance use and HIV among young Black men who have sex with men (MSM)

by

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Dedication

As part of my application for the UCSF nursing doctoral program, I included the following statement: I want to continue researching and working in the HIV/AIDS arena during my time in the PhD program and your university is the perfect fit for my interests. As I further my education, I will be able to investigate and research the healthcare needs and nursing care aspects of diverse populations in a number of different settings who are infected and affected by HIV/AIDS. Blacks and Latinos are being disproportionately impacted due to late detection and diagnosis. It is imperative that further research, outreach, education, prevention, and treatment continue until a solution is found. I am extremely concerned about the young people in communities-of color, both locally and globally, that are disproportionally being impacted by this disease. I have researched and am involved with groups to help meet the needs of people living with HIV and AIDS. As a registered nurse for many years, I have personally seen the pain and devastation caused by HIV/AIDS to my clients and their family members. My work in this field as a registered nurse has taken me as far as sub-Saharan South Africa where I saw firsthand how this disease looks in an area that has the highest HIV/AIDS statistics in the world. I want to be a source of compassion and a voice for those who cannot speak for themselves. My heart breaks at seeing such wonderful men, women and children struggle to deal with to the ravages of this horrific disease. My activities to date have paved the way and impressed upon me the need to pursue a research doctoral degree. Twenty-five years after the onset of this epidemic, there is still research being carried out and I want to bring my knowledge and experience which will hopefully put an end to this disease. I plan to remain an active part of this community of health professionals and fight until a cure is found.

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This statement is still just as true for me today as it was five years ago. Today, Blacks are still disproportionately being newly diagnosed with HIV/AIDS, accounting for over half of the new cases in the United States. They are too often diagnosed late in the disease process and therefore have higher mortality. In particular, I want to continue my research study with HIV-positive young Black men who have sex with men (MSM) between the ages of 13-29 to understand the role that substance use plays in their lives. This group is the largest population of people being diagnosed with new infections of HIV/AIDS. The prevalence of HIV among young Black MSM is three to four times higher than White MSM counterparts. Young Black MSM are run-aways and homeless, being forced to survive on the streets by becoming sex workers, engaging in unprotected anal intercourse because either they or their partner are under the influence of drugs or alcohol. Studies cite crack cocaine use, sex while high on crack cocaine, marijuana and alcohol, or sharing needles for injection drugs as strongly associated with HIV infection among young Black MSM. I want to do what I can to make a difference and be a part of this effort in my community and the world.

As an older Black male living with HIV/AIDS for over 25 years, this research topic became even more personal when my nephew and the young Latino man that I have been mentoring since he was a teenager both became diagnosed with HIV. How could this have happened? Didn't I talk about and explain the challenges I was experiencing in my own life living as a result of living with this disease? Where did I miss them? What could I have done differently? Did they not understand the impact and devastation that HIV was now going to have on their young lives? Were drugs and alcohol contributing to increasing their sexual risk behavior? I had so many questions for this group of young men and not many answers. I want to know more about this younger group of MSM who have no historical perspective of how this

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disease took the lives of so many young men back in the 1980s. I want to spend the rest of my life as a researcher being a part of finding a solution and bringing an end to HIV/AIDS forever.

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of what it looked like for someone to pursue and complete a doctoral degree and make the transition to independent practitioner. You are my shero! Thank you for reaching her long arm all the way up from Orange County to San Francisco to be a part of this journey with me, being on my qualification committee and helping to validate my research findings. I couldn't ask for a better friend than you have been through the years.

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action. You role-modeled, shared your wisdom, and let me know that my research was important to my community even though I wasn't always getting it from others. You let me know that the effort was worth it.

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HIV and substance use among young Black men who have sex with men (MSM)

Raymond Austin Nation

Abstract

In the United States, young Black men who have sex with men (MSM), between the ages of 13 and 29 years have the highest rates of new HIV infections. The prevalence of HIV among this population is three to four times higher than their White MSM counterparts. Research indicates substance use is strongly associated with HIV infection among young Black MSM. Twelve HIV-negative and HIV-positive participants from the Bay Area were recruited for this qualitative narrative study to explore the following three aims: (a) describe the role substance use plays in the lives of young Black MSM, (b) describe their perceived risks for acquiring HIV, and (c) explore the historical and social contextual experiences that have influenced their lives. The four major findings include: (1) “there was a lot going on in the homes of these participants.” Almost all of the young Black MSM discussed early substance use exposure in their family, including parents who were also drugs. The young men shared about broken family structures, including abuse and neglect, (2) thirty years into the AIDS epidemic, stigma and homophobia continue to be an issue for young Black MSM. Most of the participants were either kicked out of their family homes, asked to leave by their family, or wanted to get away from their family so that they could be themselves, (3) with the prevalence and exposure to methamphetamine in the San Francisco, young Black MSM discover the benefits of this drug for numbing, masking, and coping with everything from being gay, gay sex, dealing with peer pressure, and for sexual enhancement and survival sex, and (4) once under the influence of methamphetamine, the

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participants don't care about condoms, nor do they have the ability to negotiate condom usage with their partners. There is a sense of anticipation, resignation and acceptance about acquiring HIV; HIV risk reduction apathy. Implications of this study highlight the need for young Black MSM to have earlier substance use and HIV prevention education that include condom negotiation skills, safe spaces for empowerment and community, and increased reduction of stigma and homophobia within the Black community.

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Chapter 1: The Study Problem

Introduction

Thirty years into the AIDS epidemic, there are 36.9 million people globally living with HIV, of which 2.0 million people were newly infected in 2014 (World Health Organization). Of the 1.2 million people infected with HIV in the United States, youths between the ages of 13 to 29 years account for approximately 20,000 new HIV infections every year; that is, 55 new young people being infected with HIV every day. According to the National Institute on Drug Abuse [NIDA] (2012), about 1 out of every 6 new HIV infections was in people between the ages of 13 and 25 years. An estimated 40,000 young people in the United States have progressed from being HIV-infected to being diagnosed with AIDS (VanDevanter et al., 2011). HIV-infected youths are largely racial and ethnic minorities residing in poor urban neighborhoods, unemployed, with limited education, vulnerable to health risk behaviors and higher rates of sexual risk behaviors (Sutton, 2011).

Black Americans are the racial and ethnic minority group most affected by HIV and have the most severe burden of all racial and ethnic groups in the United States (CDC, 2015). Despite representing only 13% of the United States population, Black Americans disproportionately account for 51% of new HIV infections (NIDA, 2012); 8 times that of Whites, based on population size (CDC, 2015). At some point in their lifetime, an estimated 1 in 16 Black American men and 1 in 32 Black American women will be diagnosed with HIV (CDC, 2015). Black Americans, more than any other racial or ethnic group, are more likely to have sexually transmitted infections (STIs), which put them at risk for acquiring HIV (Mimiaga et al., 2009). Among all Black American men who are HIV-infected, the primary transmission category remains sexual contact with other men (72%), whose HIV prevalence is comparable to those seen in the developing world (CDC, 2015; Mimiaga, 2009; Miller, Serner, & Wagner, 2005).

Statement of the Problem

Young Black men who have sex with men (MSM), between the ages of 13 and 29 years, have the highest rates of HIV infection in the United States, rates that are three to four times higher than White MSM who have HIV infection (Fields et al., 2011; Harawa et al., 2004; Magnus et al., 2010; Sandfort, 2008; VanDevanter et al., 2011; Warren et al., 2007). In 2004, the HIV infection rate for young Black MSM between the ages of 13 and 19 years was 19 times (23.5%) higher than it was for White MSM (1.2%) (Feldman, 2010). Moreover, Feldman notes that young Black MSM were more likely to become infected at younger ages (13 to 29 years) as compared to White MSM who were older at the time of HIV infection (30 to 39 years).

For young Black MSM, there was a 93.1% increase in the incidence of HIV infections between 2001 and 2006 and a 48% increase in the incidence of HIV infections between 2006 and 2009 (Malebranche, Gvetadze, Millett & Sutton, 2011). Minority men ages 13–24, predominantly from the South, experienced the greatest increase (53 percent) in HIV infections of all groups studied over the 3-year period. The underlying causes of these statistics among young Black MSM, thirty years into the AIDS epidemic, are a major public health concern.

Young Black MSM, between the ages of 13 and 29 years, are one of the new faces of the AIDS epidemic and it is unclear why this is occurring since this population has a lower age of sex initiation, fewer sexual partners, less substance abuse, and lower sexual risk behaviors as compared to White and Latino MSM in the same age group (Harawa et al., 2004; Magnus et al., 2010; Warren et al., 2007). Sexual promiscuity and experimentation, usually under the influence of drugs or alcohol, often causes young Black MSM to seek out sex in high-risk venues such as public cruising areas (Mimiaga et al., 2009; VanDevanter et al., 2011). Their lack of judgment to

make sound decisions about using condoms often occurs when under the influence of drugs or alcohol.

Young Black MSM between the ages of 13 and 29 account for over 50% of new HIV infections and it is unclear why this epidemic is occurring among this population (Harawa et al., 2004; Magnus et al., 2010; Warren et al., 2007). The prevalence of HIV/AIDS among young Black MSM is disproportionately high compared to young White, non-Hispanic MSM, a disparity that continues to be ignored by researchers and current funding efforts (Harawa et al., 2004; Magnua et al., 2010; Sandfort, 2008; VanDevanter et al., 2011; Warren et al., 2007; Weidman-Hightow et al., 2011). Research indicates substance use is strongly associated with HIV infection among young Black MSM (Harawa et. al, 2004; Harawa et al., 2008; VanDevanter et al., 2011).

Young Black MSM with substance use issues face the risk of acquiring HIV/AIDS and passing it along, either knowingly or unknowingly, to their partners because of their lowered sexual inhibitions brought about by using drugs or alcohol (Harawa et al., 2004). From the limited extant literature, it is difficult to ascertain the specific role that substance use has in the experiences of young Black MSM. Substance use during sex remains underexplored among young Black MSM in the United States (Mimiaga et al., 2010).

Purpose of the Study

This research will address gaps in knowledge related to the perceptions and experiences of young Black MSM about substance use and HIV. Minimal qualitative research has been conducted specifically with young Black MSM about these issues. A majority of the studies in the literature review were quantitative in nature and focused primarily on the prevalence of HIV/AIDS and high risk behaviors of MSM in large, urban cities within the United States. Some

of the studies consisted of mixed quantitative and qualitative designs, with both primary and secondary data collection methods. The literature review does not provide a clear picture of this particular population thus information obtained from this qualitative study will prove to be invaluable in contributing to the science in this area.

Research Aims

Aim 1.

Understand the role that substance use plays in the lives of young Black MSM.

Aim 2.

Describe the perceived risks for acquiring HIV among young Black MSM.

Aim 3

Explore the historical and social contextual experiences that have influenced young Black MSM.

Innovation

Research on substance use overwhelmingly focuses predominantly on White MSM with limited Black MSM representation in study samples (McKirnan et al., 2001). Other studies have been done primarily with young White MSM and have a small number of young Black MSM as a comparison group. The limited studies currently available have been done to quantify the type of drugs being used by young Black MSM and the amount of that drug use utilizing surveys, questionnaires, or large national data sets (Harawa et al., 2004; Harawa et al., 2008; VanDevanter et al., 2011). The studies are typically done with either older Black MSM or Black men who have sex with both men and women (MSMW) with often very few numbers of young Black MSM included (Fields et al., 2011). Quantitative studies do not allow for more in-depth exploration of how young Black MSM understand or give voice to their experience and the complexities of what may put them at increased risk for HIV. This gap in the literature is even broader for understanding the lived experiences of young Black MSM between the ages of 13

and 29 years. Thus, a qualitative narrative methodology might help to provide a more in-depth descriptive account of the perceptions of young Black MSM about substance use in general, the role of substance use in acquiring HIV and other STIs, and the intersection of race/ethnicity, gender, and sexual identity and orientation on sexual and substance use risk, preference, and behavior.

Chapter 2: Review of Literature and Conceptual Framework

Overview of Relevant Research

PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus, Cochrane, and PsychInfo were utilized for this literature search using terms such as ‘young Black HIV MSM’, ‘HIV Black MSM’, ‘Black HIV Youth’, and ‘Black MSM transmission’ with mesh terms of ‘transmission’ and ‘substance abuse’ with the latter terms giving the most relevant articles ($n = 78$). The term ‘Black Male HIV’ yielded the largest results ($n = 3,061$), but many of the articles were about males and females with HIV infection. Additional search terms were ‘African American men who have sex with men’ ($n = 256$) with mesh terms ‘young MSM’ ($n = 84$) and ‘substance use’ ($n = 14$). In addition, articles were reviewed using the terms ‘Black men HIV transmission’, ‘Black HIV transmission’, and ‘HIV transmission’ with mesh terms ‘young men who have sex with men’ and ‘Black MSM’.

Only peer-reviewed articles dating back to 1990 were selected because this date correlates to the decade in which there was a dramatic increase in numbers of young Black MSM becoming infected with HIV (Denning, Jones & Ward, 1997; Malebranche et al., 2011). The search was narrowed to articles that specifically discussed substance use involvement and HIV transmission risk behaviors. From these articles, key scientists in this area were identified and a further search of their work and the references they utilized was done to locate any additional related articles.

The literature review focuses primarily on young, Black MSM, HIV and substance use, and is organized into the following sections: (a) sexual identity, preference and behavior, and (b) role of substance use in HIV transmission. The paper concludes with a summary of the literature, gaps in and limitations of the science, further research with this population, and conclusions.

Sexual Identity, Preference, and Behavior

Heterosexual transmission is the leading mode of exposure for new AIDS cases among Black MSM because they are unwilling to identify themselves as gay or bisexual, and as such have been called non-gay identified (NGI) or on the down-low (DL) for fear of encountering violence or incurring other negativity (Magnus et al., 2010). Non-gay identified men, men on the DL, as well as men previously incarcerated, are uncomfortable discussing anal sex experiences (Miller et al., 2005). Behavior change is an important strategy in preventing the spread of HIV. Thus, understanding sexual identity, preference and behavior of young Black MSM is important to minimize the spread of HIV in a community that already carries a high burden of HIV and STIs (McKirnan, Venable, Ostrow & Hope, 2001).

Miller and colleagues (2005) explored sexual diversity among 21 substance-using Black MSM in an inner-city community; 20 men used crack and the remaining one described himself as an alcoholic. The men lived in an area of Brooklyn that had a high prevalence of HIV infections. The researchers wanted to examine community-level influences and individual-level HIV risk practices by doing quantitative interviews and focus groups. Expecting difficulty recruiting a diverse and hidden sample of Black MSM, they identified and recruited men through multiple studies and venues in the area. The researchers did a series of in-depth life history interviews and identified central themes in the narratives including MSM identity and behavior, sex partner-seeking strategies, sex practices, drug use, and community factors thought to influence sex partner choices and behaviors. Two thirds of the men self-identified as either heterosexual (43%) or bisexual (24%), conforming to masculine social role expectations while downplaying their sexual identity out of fear of potential violence or incurring negativity. The older men identified potential sex partner through sex clubs while the young men used the

internet and phone services. The men were uncomfortable talking about anal sex. All of the men were sexually active with both men and women, but rarely used condoms. The relationships with women were essential to maintain appearance to be “straight” so they could succeed in life. Sixteen (76%) of 19 men already had (67%) or wanted (9%) children.

The study concluded that stigma associated with both HIV infection and homosexuality effectively insures that MSM sexual preferences and practices will remain hidden. Furthermore, most Black MSM are unlikely to respond to interventions targeting the mainstream gay population. Since little is known about the sex practices and preferences of Black men, this study adds to the understanding of experiences of Black MSM, although these men were not exclusively MSM. Unfortunately, the mean age of the men in this study was 40 years old, with only 3 men younger than 30 years old and so it adds only some value to the understanding of young Black MSM. The authors identified that substance use does seem to play a role in some sex partner-seeking strategies, but this was not clearly presented in the findings.

Masculinity and gender role conflict play an important role in the selection of partners for young Black MSM, who are often viewed as the effeminate, receptive anal sex partner, while his sex partners, who are often older Black MSM, are perceived to be in the masculine role, as the insertive anal sex partner (Malebranche et al., 2011). Ninety percent of young Black MSM tend to have sex with older Black MSM who are more likely to be NGI or on the DL, HIV-infected or unaware of their HIV status, appear to be healthy, and identify as heterosexual (Denning, 1997; Magnus, 2010; Warren et al., 2007). The older Black MSM partner is trusted to be monogamous, trusted to keep young Black MSM safe and free from HIV transmission, and responsible for making decisions about condom use, usually choosing to forego using condoms (Fields et al., 2011).

Warren and colleagues (2007) conducted a study to explore how development of identities (e.g., gay, ethnic, and masculine) impact HIV risk and protective behaviors in order to build a conceptual model that guides development of culturally appropriate interventions to reduce unprotected sexual encounters. The study reported on a sample of young MSM from three ethnic and racial backgrounds recruited from community venues who participated in a mixed methods study. The sample consisted of 189 gay, bisexual, and questioning youth between the ages of 15 and 22 years old—71 African Americans, 69 Hispanic, and 61 Whites from South Florida and Chicago. The study was a specific investigation of the predictors of unprotected sex within ethnic groups so that effective, culturally tailored interventions to reduce HIV risk among young MSM could be developed. The researchers hypothesized that cultural (lower ethnic identification, less attachment to the gay community), developmental (younger age, young age at initiation of sexual behavior) and relationship factors (being in a long-term relationship, having been kicked out of the home) would be associated with unprotected sex for each of the three ethnic groups. They also hypothesized that the strength of the associations would be different for each of the three racial and ethnic groups. The main dependent variable was unprotected anal sex with a man. Statistical testing was done across and within the three ethnic groups. The researchers identified variables with p values of 0.20 or lower for each ethnic group because use of more traditional significance levels (e.g., 0.05) might fail to identify important relationships.

Drug use comparison found that African Americans were less likely to report cocaine use or methamphetamine use in the last 90 days than either Hispanics or Whites. Alcohol use was highest in all three ethnic groups. For sexual behavior, African American participants were more likely than Whites to have ever had vaginal sex and were less likely than Hispanics to have ever had receptive anal sex. For African Americans, unprotected sex was associated with being in a

long-term relationship, having been previously kicked out of the home because of their sexual orientation, and younger age at initiation of sexual behavior. For African American youth, the statistically significant associations were in the hypothesized direction. Because of the level of trust and acceptance typical in long-term relationships, the association between being in a relationship and unprotected sex was not unexpected. Even with the limited sample size, the findings could suggest that prevention messages are not effectively reaching African American youth and conveying the importance of protecting oneself, even within a long-term relationship. The moderate sample size precluded development of a model. The assessment did not include questions about condom use while under the influence of drugs or alcohol, but the study does add to an understanding about the factors contributing to HIV sexual risk among young Black MSM.

Fields and colleagues (2011) conducted an interpretive phenomenology qualitative study to explore HIV risk and perceptions of masculinity among young Black MSM. The convenience sample consisted of 35 young Black MSM, age 18 to 24 years, living in New York and Atlanta. This was a secondary analysis that used semi-structured interview data from three previous studies to explore social-environmental factors that may influence how young Black MSM assess risk, choose partners, and make decisions about condom use. The convenience samples were previously recruited from internet chat rooms, local parks, community-based organizations, bars, bookstores, advertisements in newspapers targeting Black community using postcards, and snowball created a more diverse overall participant sample.

The perception of masculinity was the primary factor influencing partner selection, risk assessment, and decision-making with regard to condom usage. Four primary themes emerged: (1) greater preference for partners perceived as masculine; (2) discomfort with allowing men

perceived as feminine to be the insertive partner in anal intercourse; (3) a power dynamic such that partners' perceived as more masculine made condom-use decisions with the dyad; and (4) use of potential partner' perceived masculinity to assess HIV risk. Preference for masculine partners among young Black MSM has potential ramifications for HIV risk and may be an important concept to consider in prevention strategies directed toward this population.

Limitations include varied sampling strategies across sites that may have involved selection bias. Focus groups of different subpopulations of young Black MSM (e.g. younger, non-gay identified, etc.) would have made comparisons more readily available, but the depth of the data, a significant strength of this study, would have been compromised. This study did help elucidate quantitative findings of similar populations of young Black MSM, particularly those findings that suggest that partner characteristics influence HIV risk. These finding may also help generate additional hypotheses about HIV risk in this population that can be tested quantitatively and generalized to the appropriate young Black MSM population. This is one of the more recent studies done exclusively with young Black MSM.

The intersection of sexual identity, gender, and race and ethnicity can further compound behavioral change interventions targeted toward young Black MSM who have HIV infection. Wong, Weiss, Ayala and Kipke (2010) examined the prevalence of illicit drug use as it relates to gay-related racism, sexual racism, intimate partner violence, homophobia, verbal harassment, discrimination experienced by young Black MSM compared to White and Latino MSM counterparts in Los Angeles. Illicit drug use is associated with all of these issues. The sample of 526 young MSM with 39% of the sample being 18-19 years of age included: 195 (35%) White, 126 (24%) African American, and 205 (39%) Latinos of Mexican descent. Eighty-three percent of respondents self-identified as gay or some other same-sex sexual identity. This cross-sectional

study that is part of a larger longitudinal study; these findings come from the baseline assessment. Recruitment was done at setting and events at which young MSM were observed to spend time such as bars, coffee houses, parks, beaches, high-traffic street locations; social events such as a picnic or baseball game sponsored by youth-serving, community-based organizations; and special events such as gay pride festivals. Surveys were administered in both English and Spanish using audio, computer-assisted (ACAI) interview technologies to improve quality and validity of subjects' responses. Statistical analyses were done across the three racial and ethnic groups of all the various survey instruments.

The African American participants were significantly more likely to report experiencing two or more types of financial hardships while growing up. African American participants were significantly less likely to report experiences of homophobia while growing up and less likely to use drugs. However, they were more likely to report experiences of racism in gay social settings and/or sexual relationships or institutional racism as well as more likely to report sexual intimate partner violence and be the perpetrator of same. The limitations of this study are the self-reported behaviors which cannot be independently verified. This data may be underestimated since some of these behaviors may be perceived as socially undesirable. The data is cross sectional and therefore do not contain information about the temporal relationship between violence and social discrimination variables with illicit drug use. Also, this sample was recruited through gay-identified venues and is certainly not representative of the larger young MSM population. This study highlights some of the factors that may play a role in the substance use experiences of young Black MSM when cross- group comparisons are done.

Wong and colleagues' (2010) findings suggest young Black MSM are not likely to attend or respond to interventions targeting the mainstream gay White population because they feel

uncomfortable, perceive they are not accepted as part of the gay community, and prefer not to discuss their perceived socially-unacceptable attraction to other men with those who are non-Black. This discrimination of young Black MSM, who tend to be of a lower socioeconomic background, serves only to further remove access to limited resources and services available to protect them from HIV infection (Denning, Jones, & Ward, 1997).

Role of Substance Use in HIV Transmission

Men who have sex with men and have substance use issues face the risk of getting HIV because of their lower sexual inhibitions and/or passing it along either knowingly or unknowingly to their partners. In California, marijuana is the most frequently used, abused and dependent-related drug for young adults between the ages of 16 and 25 years (Cerda, Wall, Keyes, Galea, & Hasin, 2012). Harper and colleagues (2012) report states like California that legalized medical marijuana had higher rates of marijuana use, abuse, and dependence among adolescents, and they believe these higher rates are due to the greater promotion and availability of marijuana for recreational drug use. Furthermore, the definition of what medical conditions warrant appropriate or necessary treatment with medical marijuana is vague and not the same in all states. This finding might correlate to the high use of marijuana in young Black MSM in those states.

Research indicates sex while high on marijuana, crack cocaine, and alcohol is strongly associated with HIV infection among young Black MSM (Harawa et al., 2008). Using qualitative methodology, Harawa and colleagues examined sexual behavior, sexual identity, and substance abuse in a sample of 46 low-income bisexual and non-gay-identifying (NGI) Black men who have sex with men or with both men and women (MSM/MSMW) in Los Angeles. Two-thirds (n = 30) of the participants were HIV-infected and the mean age was 41.5 years old. The

researchers analyzed qualitative data from seven focus groups discussions in order to explore the role that drugs and alcohol play in sexual behaviors with other men, sexual identity, and the meanings attached to same-sex sexuality. Recruitment involved active and passive distribution of fliers at nightclubs, coffee houses, HIV clinics, social service agencies, and street/park locations commonly frequented by the population. Most of the venues were not gay-identified.

The finding included four overarching domains that include drug and alcohol use and transactions as *motivators*, *allowers*, *rationalizers*, and *facilitators* for having sex with other men. They discussed how these four roles help to decrease cognitive dissonance regarding issues of masculinity and participation in same-sex sexuality but also how they complicate a fifth domain, *recovery from drug addiction*, for some of the men in this study. Participant quotes were provided to give meaning to these domains. Even though this study was done with older Black MSM, the finding may help inform consideration that need to be taken into account when working with young Black MSM since they can also be non-gay identified and be engaging in high risk sex with both men and women. Additional limitations include doing focus groups which have the potential for social desirability bias and “group think” instead of one-on-one interviews which might have minimized this effect. Also, because the original study objectives were not to fully explore substance use and same-sex sexuality, the question regarding drug use was one small part of the interview guide.

Purcell and colleagues (2001) conducted a descriptive, cross-sectional study to explore substance use and sexual transmission risk behavior in a sample of 456 HIV-infected MSM, most of whom are men of color (29% African American, 24% Latino, 30% white, 6% Asian or Pacific Islander, 1% Native American, and 8% mixed race). Mean age was 37 year old and 83% identified as gay, queer, or homosexual. Approximately 61% of the men were recruited in New

York City (n = 279) and 39% from San Francisco (n = 177) from venues such as AIDS service organizations, gay bookstores, gay pride events, gay neighborhoods, bath houses, and outdoor cruising areas. The researchers examined (1) the association between drug use and sexual transmission risk and (2) the associations between drinking and drug use before or during sex and sexual transmission risk. About half of the men in Phase 1 (n = 250) completed in-depth, face-to-face qualitative interview and completed a quantitative study while the men in Phase 2 (n = 206) completed only the quantitative survey.

Most men (71%, n = 325) reported using a substance; almost two-thirds drank alcohol and nearly half used non-injection drugs (marijuana and popper were the most popular), with the majority of them drinking or using before or during sex. Men who used a greater number of substances engaged in more unprotected receptive anal intercourse (URAI), primarily with casual partners, compared to those who did not use. Substance use clearly continues to be an issue for HIV-infected MSM, either selectively or purposefully in the context of sexual encounters. In this study, obtaining a random sample of a hidden population was difficult for the researchers. In addition, extra effort was expended to target men of color and men from venues believed to connote riskier sexual behavior. Also, one third of the sample were recruited from bars where substance use are more prevalent, particularly in New York City and San Francisco where the prevalence of MSM who use three or more drugs is higher than in Los Angeles or Chicago. The amounts of alcohol or drug use were not quantified in this study. Finally, self-administered surveys can lead to socially desired responses. This study might help inform substance use behaviors with young Black MSM or the drug use patterns may be different.

As demonstrated in the aforementioned study conducted by Purcell and colleagues (2001), substance use before or during sex among MSM is related to receptive anal intercourse

because it makes it easier or more comfortable. Since the overwhelming majority of research on substance use in MSM focuses on large samples of White MSM, with limited representation of Black MSM, drug use is not well documented among entirely Black MSM samples in the United States.

Mimiaga and colleagues (2010) explored stimulant use during sex and HIV risk behavior among Black MSM living in Boston doing quantitative assessments with a trained interviewer. The respondent-driven sample consisted of 197 urban Black MSM who reported oral or anal sex with a man in the preceding 12 months. Only one person tested HIV-infected during the testing offered as part of this study. The mean age was 38.7 years old. The purpose of this study was to examine the frequency of stimulant use during sexual behavior with male and female partners and to identify which subgroups of Black MSM were most likely to use stimulants during sex. Half of the men (52%, n = 103) in this study identified as bisexual or heterosexual.

One-third (34%) of Black MSM reported using stimulants monthly or more frequently during sex in the past 12 months. The following factors were significantly associated: (1) demographics - older age, being publicly insured, and unstable housing; (2) HIV sexual risk and substance use - unprotected anal sex with a casual male sex partner, unprotected vaginal or anal sex with a female sex partner, perceiving that they were at greater risk for HIV and STDs, and popper use and erectile dysfunction medication use; (3) HIV sexual risk and substance use during most recent sexual encounter - serodiscordant unprotected anal sex with a casual male partner, and having met sexual partner at a bar or dance club; (4) presenting psychosocial issues - problematic alcohol use, clinically significant depressive symptoms, higher levels of HIV treatment optimism, and less supportive condom use norms; (5) lifetime psychological history - substance abuse treatment, and having exchanged sex for money. This study highlights the

importance of investing in and refining new behavioral treatment approaches to stimulant abuse/dependence as an important strategy that could also benefit young Black MSM as well. The limitations of this study included the survey being interviewer administered and responses could have been biased toward social desirability; self-reported sexual risk and drug use behaviors were probably underreported. The researchers identified resource limitations determined sample size which did not allow for recruitment chains to continue so the sample might not be representative to the Black MSM population. Finally, the various types of stimulants were grouped together so it limited the ability to draw comparisons across these drugs.

Drugs and alcohol are used often as a socially acceptable escape to cope with stress, enhance sexuality, and escape self-awareness of HIV risk among MSM. McKirnan and colleagues (2001) examined the relationship between sexual escape expectancies and the number of unprotected receptive anal sex episodes in a sample of 139 African American (65% identified as gay) and 112 White, non-Hispanic MSM (98% identified as gay) who use alcohol and drugs in Chicago. The mean age was 34 years old. In both groups, over 80% of participants who reported being HIV-negative had been tested within the previous year. The researchers describe sexual escape expectancies as the ability of alcohol and drugs to help a person escape self-awareness of personal vulnerability of HIV or cognitive escape from awareness of past or ongoing HIV risk behavior. Such escape coping is facilitated by activities that shift self-awareness from the abstract or long-term implications of behavior to immediate, 'here and now' sensations or actions. This may enhance risk by lessening one's capacity or motivation to monitor safer sex norms. The majority of the participants (41%) were recruited through direct face-to-face outreach in bars, clubs, cruise areas and similar settings, while the remaining came

from HIV/STD testing and treatment clinics, flyers, and snowball sampling. The researchers recruited participants from a structured, workshop-based behavioral intervention designed to promote safer sex among men who combine alcohol and drugs with sex. The data for this study came from baseline interviews with participants screened for enrollment in a controlled behavioral outcome trial of a safer sex intervention.

Two general hypotheses were tested: (1) that specific patterns of combining alcohol or drugs with sex underlie sexual risk. Subgroups were formed based on substance use patterns during recent sexual activity, examined ethnic difference in groups, and tested group differences in HIV risk behavior, infection status, and psychosocial variables (e.g., expectancies and bar use) and (2) the effects of expectancies for sexual escape, personal standards for sexual safety, and participants' use of bars or clubs as a social focus, on sexual risk. The researchers hypothesized that there would be direct effects of each of these variables on rates of unprotected anal intercourse. The key hypothesis was that escape motivation would moderate the effect of drug use on risk. Support for this hypothesis would help clarify the mechanism whereby drug use increases risk. Drug or alcohol use per se may be less important to unsafe sex than is the combination of drug use and the motivation to decrease self-awareness of risk status and health concerns. Finally, they tested the competing hypothesis that the use of gay bars or clubs as personal and social resources may moderate the effect of drug use on sexual risk.

The sample was very high risk and findings showed that those who frequently combined drugs and sex reported higher rates of sexual risks and Hepatitis B infection than did men who infrequently combined substances with sex, or who combined only alcohol with sex. Sexual risk was pronounced among more frequent drug users who also reported strong expectancies that alcohol or drugs facilitate sex and cognitively escape from awareness of HIV risk. Among the

men who frequently combined drugs with sex, those with strong sexual escape expectancies reported a substantially higher percentage of sexual episodes that included unprotected receptive anal sex. Frequenting bars per se was not an important factor in sexual risk. The African American participants did report significantly more drug problems, particularly crack cocaine, and were substantially more likely than were Whites to be infected with HIV and Hepatitis B even though the groups had similar rates of unprotected sex. Participants were self-selected for substance use and sexual risk so there may be some bias. Perhaps the findings would have been different if there were less alcohol-or drug-involved men. Substance use, of course, is effective in narrowing attention to the immediate. Although the men in this study were older, the idea of expectancies of sexual escape increasing sexual risk may be similar with young Black MSM and would need to be further explored.

Study findings indicate among men who use drugs, those who had a high propensity for sexual escape also have a substantially higher number of unprotected anal sex episodes. Thus, sexual escape may be another contributing factor for the high prevalence of HIV among young Black MSM. HIV prevention may benefit from understanding and addressing the reasons why young black MSM use drugs and alcohol during sex and subsequent sexual risk taking. In addition, it would be helpful to promote safer sex without the use of drugs and alcohol.

Summary, Gaps and Limitations, Further Research, and Conclusions

Summary of the Literature

Young Black MSM between the ages of 13 and 29 years have the highest rates of HIV infection in the United States even though they initiate sex at a younger age, have fewer sexual partners, engage in lower sexual risk behaviors, and report less substance abuse (Fields et al., 2011; Magnua et al., 2010; Sandfort, 2008; VanDevanter et al., 2011; Warren et al., 2007).

Scientific evidence indicates the HIV disparity among young Black MSM is related to several factors (Magnus et al., 2010; Mimiaga et al., 2010; Wong et al., 2010). They tend to have more frequent unprotected anal sex with high risk steady partners who are typically older, serodiscordant, and identify as heterosexual, NGI, or on the DL. In addition, young Black MSM tend to have a lack of awareness of HIV status, share needles for drug injection, and have sex while high on crack cocaine.

Young Black MSM, in particular teenagers, run away from their parents' home because of sexual identity rejection and end up homeless, forcing them to survive on the streets by becoming sex workers and engaging in unprotected anal intercourse because either they or their partner are under the influence of drugs or alcohol (VanDevanter et al., 2011). Survival sex, having sex for the purpose of meeting basic needs, is associated with high incarceration, unemployment, low socioeconomic status, and the need for money or drugs among young Black MSM (Harawa et al., 2008). Alcohol, marijuana, crack cocaine, and methamphetamine appear to be the drugs of choice among young Black MSM (Harawa et al., 2008; Purcell, Parsons, Halkitis, Mizuno & Woods, 2001). Thus, young Black MSM with substance abuse issues face the risk of acquiring HIV and passing it along, either knowingly or unknowingly, to their partners because of their lower sexual inhibitions brought about by using drugs or alcohol.

Gaps in and Limitations of the Science

Minimal research has been conducted specifically about HIV and substance use among young Black MSM. The literature review does not provide a clear picture of this particular population. Research on substance use overwhelmingly focuses predominantly on White MSM with limited Black MSM representation in study samples, although Black MSM report higher substance use in combination with sexual behavior, which puts them at greater risk for HIV

infection and other STIs (McKirnan et al., 2001). This gap in the literature is even broader for understanding the intersection of race/ethnicity, gender, and sexual identity and orientation on sexual and substance use risk, preference, and behavior.

Multiple, lengthy self-report questionnaires were the most commonly used measures to assess study variables for studies included in the literature review. Self-report data are subject to the following potential limitations: misreporting, incomplete information, poor recall, concerns about stigma, interviewer bias, cultural differences in language use, and participants providing inconsistent and socially-desirable responses (Harawa et al., 2004; Magnus et al., 2010). Moreover, self-report data potentially minimize generalization of study findings in quantitative studies and transferability of study findings in qualitative studies. In several studies, participants were asked to complete five or more questionnaires that query sensitive information about sexual behavior, drug and alcohol use, depression, HIV transmission, condom use, perceived HIV and STI risk, history of incarceration, history of sex work, etc, which could potentially lead to participant burden and fatigue and threats to internal validity, Wong and colleagues (2010) used computer-assisted interview technology to ask participants 1,109 different questions.

Further Research

Young Black MSM's sexual identity and social contextual factors make this hidden population challenging to capture in research because they are not likely to respond to recruitment advertisement for gay and bisexual men and they are not likely to be reached easily in locations that cater to MSM or HIV service organizations. More research is needed to better understand why and how young Black MSM use substances in general and in the context of sex, and whether higher substance use during sex is due to this community's acceptance of such use as a social norm. What was the role of substance use as well as other adverse childhood

experiences in young Black MSM's upbringing among family members? Do they use substances to cope with their feelings about same-sex attraction? A better understanding is needed about how young Black MSM's sexual identity, risks and behaviors contribute to their relationships with others, having unprotected anal sex with older Black MSM who identify as heterosexual, NGI, or on the DL, and to the transmission of HIV and other types of STIs. Further exploration of these foci would be a significant contribution to science in this area.

Conclusions

HIV continues to have an increasing impact in racial and ethnic minority communities, especially among young Black MSM, despite national strategies, interventions, and programs. There is a need to develop interventions and prevention education strategies with targeted messages that are racially- and ethnically-appropriate for this population. Young Black MSM need to understand the relationship between substance use and how it influences their ability to make decisions about protecting themselves against HIV infection and other STIs. Expected long-term health outcomes are decreased substance use, decreased HIV and STI transmission risk in this population, improved health of young Black MSM, and decreased HIV disparity. More research is needed to fully understand the experiences of young Black MSM and the range of factors contributing to the disproportionate numbers of new HIV infections.

Conceptual Approach

Harm Reduction

Harm reduction, which is grounded in public health tradition and operationalized within a health promotion framework, has been modified over time to reduce risk and promote personal and community health through social, environmental and cultural dimensions (Erickson, 1995; Erickson, 1999; Hilton, Thompson, Moore-Dempsey & Janzen, 2000). The conceptual approach

known as harm reduction has changed through the decades since first presented (Erickson, 1995). Harm reduction entails the idea of acceptance of the behavior brought on by substance use and drug addiction while at the same time making small attempts to minimize, not eliminate, the harmful consequences brought on by alcohol and substance use rather than trying to eliminate such use altogether (Erickson, 1995, Erickson, 1999; Hilton, Thompson, Moore-Dempsey & Janzen, 2000). During the AIDS epidemic, the focus changed to reducing the cost and spread of HIV among intravenous drug users (Hilton, Thompson, Moore-Dempsey & Janzen, 2000), including support for measures such as needle exchange programs.

In the United States, harm reduction and needle exchanges have been less successful because of the long-standing opposition to needle exchanges and restriction of the use of federal funds for such programs in place for more than twenty years (Hilton, Thompson, Moore-Dempsey & Janzen, 2000). Research has shown that needle and syringe exchanges are key to addressing HIV and AIDS sustainability in the United States and that expanding syringe exchange programs (SEPs) would avert hundreds of HIV infections and save three times the amount of investment needed to implement the programs (Nguyen et. al, 2012).

Based on literature to date, there appear to be five concepts within this conceptual approach: (1) decreasing the consequences of harmful behavior, (2) acceptance of alternatives to abstinence, (3) respect for the individual's ability to make rational, informed decisions, (4) reduction of barriers to treatment, and (5) compassionate pragmatism. Each of these will be discussed individually.

The first concept presumes that for the present the user is going to continue their substance use and this is accepted as a fact (Walch & Prejean, 2001). Harm reduction understands substance use as complex, multifaceted phenomenon that encompasses a continuum

of behaviors from severe abuse to total abstinence; it acknowledges that some ways of using drugs are clearly safer than others (Weiker, Edgington & Kipke, 1999). Harm reduction is an umbrella term for interventions aiming to reduce problematic effects of substance use behaviors (Logan & Marlatt, 2010). Young adulthood is a period of identity formation and experimentation, including risk-taking, whether it be unsafe sex or substance use (Paglia & Room, 1999). With any drug prevention program for young adults, the main goal should be to reduce levels of drug-related harm—harm to the user, as well as harm to others including any harmful behavior (Paglia & Room, 1999). The consequences of harmful behavior for substance users should be less punitive (Erickson, 1997; Hilton, Thompson, Moore-Dempsey & Janzen, 2000). Harm reduction holds promise to decrease the unhealthy consequences experienced by both the substance user and non-drug-using community (Philips & Rosenberg, 2008).

The second concept, acceptance of alternatives to abstinence, was originally developed as a part of nonabstinence-based methods of treating people with drug and alcohol problems (Little & Franskoviak, 2010). Harm reduction offers a beginning point when abstinence-only methods are not effective or realistic for a specific client (Logan & Marlatt, 2010). The unifying principle of harm reduction is that the substance user does not have to quit to reduce harm or to resolve their problems with drugs. Even though harm reduction supports abstinence as a worthy goal, it is not the only goal, and it is legitimate goal only if proposed by the client (Little & Franskoviak, 2010). Paglia and Room (1999) describe abstinence as the “ultimate risk-reduction goal” (p. 15) and it “is of course the only way to avoid all negative consequences associated with substance abuse” (Logan & Marlatt, 2010, p. 202). Other than that, harm reduction is neutral regarding long-term goals and involves a prioritization in which immediate and realizable goals take priority when dealing with substance users (Walch & Prejean, 2001).

The third concept, respect for the individual's ability to make rational, informed decisions, emphasizes that the substance user is treated with dignity as a normal human being and responsible for their own behavior (Walch & Prejean, 2001). Many young adults may not view substance use as a problem and an abstinence-based method may be seen as too extreme and not match social norms of the environment (Logan & Marlatt, 2010). National surveys have noted that the majority of heavy drinkers and drug users are employed full-time, frequently in workplace cultures that support alcohol and drug use (Logan & Marlatt, 2010). Harm reduction works well if a substance user is not yet interested, unwilling, or unable to abstain completely (Weiker, Edgington & Kipke, 1999). Providing a choice of goals may increase an individual's motivation to change substance use behavior and ease into a controlled, moderated, or abstinent lifestyle (Marlatt & Witkiewitz, 2002). When individuals are given a choice of goals, many people choose abstinence (46%) and over the course of treatment there is more movement in the direction of moderation to abstinence goals (Marlatt & Witkiewitz, 2002).

Reduction of barriers to treatment is the fourth concept. Given the frequency of relapse and the unwillingness of some substance users to undertake treatment, many clinicians are coming to recognize the value of harm reduction as both a treatment goal and set of interventions designed to reduce the unhealthy medical, psychological, and social outcomes of ongoing drug use (Philips & Rosenberg, 2008). "Dozens of peer-reviewed controlled trials publications provide support for the effectiveness of harm reduction for a multitude of clients and disorders without indications of iatrogenic effects" (Logan & Marlatt, 2010, p.201). The iatrogenic effect describes the unintentional harmful effects induced inadvertently by a provider or by medical treatment, intervention or advice. The term is used in prevention science where programs are shown to have detrimental effects on outcomes. This concept implies that providers should meet

the client where they are at and allow the client to direct treatment goals, helping them along as far as they will allow in the direction of positive behavior change (Logan & Marlatt, 2010; Marlatt & Witkiewitz, 2002). “Harm reduction supports any step in the right direction” (Logan & Marlatt, 2010, p. 202) and means not withholding treatment or services when a client will not or cannot meet the ideal treatment outcomes (Logan & Marlatt, 2010).

The final concept, compassionate pragmatism, addresses an approach to the prevention and treatment of problem drinking and drug use that shifts the focus away from the substance use itself to the consequences of harmful substance use behavior (Marlatt & Witkiewitz, 2002). Merriam-Webster (2014) defines pragmatism as a reasonable and logical way of doing things or of thinking about problems that is based on dealing with specific situations instead of on ideas and theories - a practical approach to problems. According to Marlatt and Witkiewitz (2002), harm reduction offers a pragmatic approach to substance use based on three core objectives: (1) to reduce harmful consequences associated with substance use; (2) to provide an alternative to zero-tolerance approaches by incorporating substance use goals that are compatible with the needs of the individual; and (3) to promote access to services by offering low-threshold alternatives to traditional substance use prevention and treatment. These occur within a context of empathy toward the individual and his/her life struggles.

Harm reduction has the potential for broader acceptance and utilization when working to understand substance use and HIV young Black MSM, particularly since harm reduction programs are popular and prevalent in the Bay Area as the preferred framework to work with reducing adverse outcomes from substance use or sexual risk behavior. Harm reduction provides a framework for assessing and intervening in complex health-related behaviors that are typically associated with substance use, drug addiction and sexual risk behavior.

According to Erickson (1995), utilizing harm reduction with young people provides for more open, honest exchange of information in a way that is respectful of their ability to make their own choices around alcohol and substance use with the hope of avoiding disastrous outcomes. In addition, some young people will have community exposure with substance use because of where they live and socialize; many will experiment with drugs without adverse consequences while others may use them in amounts and situations that can lead to serious harm or never use drugs (Erickson, 1995; Erickson, 1997). We must concern ourselves with the well-being of young people and understand the punitive policies of the criminal justice system, while moving our drug education programs towards prevention or harm reduction (Erickson, 1997).

Harm reduction has continued to grow over the last 18 years as an alternative approach to treating substance use (Little & Franskoviak, 2010). In addition, harm reduction has been receiving increasing attention in the fields of addiction treatment and provides a framework for managing high risk behaviors associated with substance abuse (Walch & Prejean, 2001). Harm reduction for young Black MSM must be multidimensional in approach, meaning that there has to be an assessment of all five concepts when thinking about the best way to proceed while working with this population.

This researcher was aware of how harm reduction was being utilized by the young Black MSM in response to them managing their substance use and sexual risk behaviors. As a conceptual approach, harm reduction was beneficial in formulating the interview guide around its concepts, doing the interview, and informing data analysis. In sum, harm reduction appears to be a more useful conceptual approach for studying the phenomenon of interest. The five concepts from this conceptual approach provide an excellent template for knowledge development in studying ways to prevent or reduce adverse health consequences from substance

use and HIV among young Black MSM. There has been limited research utilizing the harm reduction conceptual approach specifically with young Black MSM. A study is needed that would contribute to that gap in knowledge.

Assumptions

The main assumption of this study is that young Black MSM have different substance use and HIV risk behaviors than their White or Latino counterparts. Young Black MSM often (a) have less education, (b) come from a lower economic status, and (c) have an unaccepting community and family structure due to their sexual orientation. These assumptions can have an impact in carrying out this research study, including locating and developing ongoing contact with young Black MSM for interview and follow-up interview.

Research Aims

Aim 1.

Understand the role that substance use plays in the lives of young Black MSM.

Aim 2.

Describe the perceived risks for acquiring HIV among young Black MSM.

Aim 3

Explore the historical and social contextual experiences that have influenced young Black MSM.

Definition of Terms

young for the purpose of this study, young is defined as under the age of 35.

MSM men who have sex with men.

MSMW men who have sex with men and women

NGI non-gay identified

substance use - also known as *drug use*, is a condition in which the use of one or more substances leads to a clinically significant impairment or distress.

Chapter 3: Methodology

Research Design

Narratives

This research was done using narratives to give voice to the stories of the young Black MSM about their experiences with substance use and HIV risk behavior. The precise definition of narratives varies and it is often used interchangeably with storytelling. Holloway and Wheeler (2010) describe narrative as stories that enable researchers to understand participants and gain access to their experiences. Riessman (1993) describes narratives as storytelling, reflections on people's experiences and meanings that past experiences have for them. "Narrativization tells not only about past actions but how individuals understand those actions, this is, meaning" (Riessman, 1993, p. 19). Generally, participants put their ordinary lives into plots with these archetypal forms - tragedy, comedy, romance, and satire (Riessman, 1993). According to Creswell (2007), a narrative is a spoken or written text giving an account of an event or action or a series of events or actions. Narrating helps people to make sense of their experience and is seen as useful for examining culture, society or social and cultural groups (Holloway & Wheeler, 2010). According to Holloway and Wheeler, through storytelling, participants were able to: (a) give meaning to experiences; (b) interpret and verbalize important events and share them with others; (c) present a holistic view of experiences and perspectives; (d) find adjustment when conditions are unalterable; (e) confirm group membership in a shared culture; (f) attribute blame or responsibility to themselves or others; and (g), take control over their lives.

Narratives contain a number of overlapping stories: everyday, autobiographical, biographical, cultural, and collective (Holloway & Wheeler, 2010). Everyday stories describe how people do everyday things and carry out normal tasks. Autobiographical stories are written and recorded by the individuals who are the subject of the study; they detail how people link the

past to the present and future to justify and explain their actions. Biographical stories are experiences of another person's life that the researcher records and writes; these stories link individuals with each other, enabling them to share and compare their experiences. Through cultural stories, people make visible and demonstrate meanings in a particular cultural context. Specifically, collective stories, utilized in this research, retell a number of stories that allow the researcher to reflect on the thoughts and paths of a group or collection of people with similar experiences in order to give a portrayal of a condition or patterns of experience.

Narrative research has limitations and is a challenging approach to use (Creswell, 2007) and one of the main issues is that of 'truth' since it is difficult for the researcher to decide on the veracity or falsehood of stories as they are retrospective and rely on memory (Holloway & Wheeler, 2010). Hidden motives might underlie the way the participant tells the story, what is withheld or included, what is dramatized or forgotten, is important for the data analysis (Holloway & Wheeler, 2010). Narrative researchers should give readers a 'thick description' of socio-cultural settings in which the narratives are embedded, while also providing a scholarly analysis and evaluation (Holloway & Wheeler, 2010). Narratives are laced with social discourses, such as feminism and power relations, as discussed later in this paper, which change over time and from one setting to the next (Reissman, 1993). Without a doubt, the stories of substance use and HIV risk behaviors among young Black MSM have the potential for high narrative importance and will contribute greatly to the current understanding of circumstances affecting this population. Narrative methodology is the best way to hear the stories, write about these experiences, and fill the scientific gap in the current literature.

Feminist Perspective Informs Methodology

Understanding substance use and HIV risk behavior among young Black MSM with can be better understood by first explaining the feminist perspective and how it influenced the research methodology for this study. According to Im (2010), utilizing a feminist approach during investigation, with a qualitative design, was the best way to explore this phenomenon. Feminists have influenced research scientists to use multiple methods to obtain various perspectives and increase the thoroughness of the findings and formulate new questions and theories (Im, 2010; Rodgers, 2005). Quantitative research has always been considered sexist and limited because most research has been done by (a) White middle class male scientist, (b) about concerns of White middle class men, and (c) for increasing the knowledge of White middle class men to support or advance prevailing scientific, social, racial, political, financial and racial issues (Godfrey-Smith, 2003; Jensen, 2004; Rodgers, 2005).

Feminist theory informs the health disparity of substance use and HIV risk behaviors among young Black MSM who are often mistreated and ignored by science, medicine, society, and policy because of race, ethnicity, and sexual orientation. Young Black MSM with substance use or HIV are stigmatized and perceived as participating in socially undesirable behaviors. As a result, many of these men share the same challenges of exclusion experienced by heterosexual women and lesbians. Historically, Black men have been treated inhumane by society since the days of slavery. This researcher questions that even with the advances of civil and voting rights for Black Americans, much of this same oppressive behavior and exclusion is still perpetuated by the scientific, social, political, financial and racist powers in this White male dominated country (Haraway, 1988). Radical feminism rejects domination and racism and is against this kind of inequality (Godfrey-Smith, 2003; Jansen, 2004). Feminist researchers are opposed to the

discrimination of the underserved and understudied, marginalized populations by scientific researchers, medical communities, and health care systems that lead to increased morbidity and mortality (Im, 2010; VanDevanter et al., 2011).

Feminist researchers are exploring new questions and analyzing differences in sexuality and sexual orientation (Im, 2010). Feminism supports people having the freedom to be in the world just as they are and having the same rights regardless of gender identity or sexual orientation. The patriarchal concept and social injustices have been harmful to men by narrowing their life choices, limiting their sexuality, and blocking full emotional connections with other men. Men who have sex with men are benefiting by the feminist activism that has occurred in support of gay rights. However, when it comes to sexual relationships, less dominant gay men usually the one receiving sexual penetration - are like women and not always able to direct or refuse to engage in sexual activity with their partner (Frasca, 2003). In addition, the Frasca (2003) noted that sexual behavior can also be accompanied by rape and other violent acts since the less dominant partner - gay men or women - can also be financially dependent and forced to endure this abuse. Formation of gay-feminist alliance could put an end to this oppressive sexual behavior along with other types of hidden sexual mistreatment of both gay men and women (Frasca, 2003). More research, similar to this type of study, is needed to continue to give voice to those populations that are omitted and marginalized by the scientific community.

Description of Research Setting

The plan was to conduct the research at community-based organizations, agencies and healthcare facilities that provided care and services to young Black MSM. The researcher composed a brief letter describing to key personnel describing who they were and their organizational affiliation. A clear description of the study objectives was provided. The

researcher also acknowledged issues and concerns around confidentiality of HIV status and the disclosure of sensitive information shared about participants' substance use. Key personnel were instrumental in posting Recruitment Flyer (APPENDIX A) and sharing information about the study with their clients using the Recruitment Information Sheet (APPENDIX B).

Sample

Human Subjects Assurance

There is always a concern for potential harm to participants in any research. The researcher informed participants of their rights as research participants and of measures taken to protect their privacy. The loss of privacy could have resulted in embarrassment and stigmatization, particularly in the proposed target population, young Black MSM with substance use or HIV. Anonymity and privacy were maintained by securing paper and electronic documents. Study records were secured in a locked file cabinet. Electronic study records were secured via password protection and encryption. Field notes and transcripts were de-identified to maintain anonymity as well as confidentiality.

Ethical Considerations

Ethics in research is not merely a process, but rather a critical component of qualitative research (Tracy, 2010). According to Tracy, ethics in qualitative research extends beyond procedural ethics encompassing situational, relational and exiting ethics. Procedural ethics is mandated by governing bodies such as the institutional review board (IRB) to protect participants from harm and deception; it guarantees privacy and confidentiality and ensures informed consent has been obtained. Situational ethics refers to the researcher making ethical decisions in any given situation inclusive of methods and the data reported. Existing ethics

reminds the researcher to observe ethical judgment in presenting the data so as to not cause undue harm or ill consequences for participants and the community.

Nature and Size of Sample

Originally, this study sought to recruit a purposive, targeted sampling of up to 20 HIV-positive, substance-using young Black MSM between the ages of 18-29 in the Bay Area. Because of challenges with recruitment and after receiving guidance and feedback from the dissertation committee, the IRB submission was modified to: (1) expand the age group from 13 - 35, (2) include both HIV-positive and HIV-negative participants, and (3) recruit throughout the State of California. As is the case with other qualitative approaches, convenient, purposeful sampling means selecting a population that can best inform understanding about the research problem (Holloway & Wheeler, 2010).

Criteria for Sample Selection

This study had a homogenous sample since it involved individuals who belong to the same subculture and who have similar characteristics (Holloway & Wheeler, 2010). The number of participants could have been larger or smaller as the researcher is not looking for generalizability, but rather to obtain different perspectives or findings that reflect differences in phenomena being studied (Creswell, 2007). The final sample size was determined by data saturation. Twelve men, who met the eligibility requirements, were recruited and interviewed. This researcher believes that data saturation was achieved with this current sample since everything of importance to the primary research aims was identified and the stories started to get redundant; this is called informational redundancy and data saturation means sampling to redundancy (Holloway & Wheeler, 2010).

Prior to being interviewed, all participants were screened according to the Telephone Screening Tool (APPENDIX C) to ensure they met the eligibility requirements for this study. There were only three people who called, were screened, and did not qualify because they were too old to participate in this study. Holloway and Walker (2010) note the importance of having both clear inclusion and exclusion criteria. All of the study participants met the following inclusion criteria: (1) self-identified black male, (2) between the ages of 13- 35, (3) live in the local area, (4) has had sex with men, (5) can speak, read, and comprehend English, (6) have a history or active substance use with alcohol, marijuana, cocaine, crack cocaine, or methamphetamine, (7) okay to have a history or current homelessness or runaway, and (8) provide informed verbal consent or written consent if under the age of 18. Based on the this researcher's background understanding of this population and the research question, it was important to allow those with varying degrees of either past or current substance use as well as those that are homeless or runaway since these circumstances may be a usual part of the experiences of young black MSM. This study is representative and reflective of the population.

Exclusion criteria were Blacks born outside of the United States because their experiences, culture, and history are different than that experienced by American youth. Participants were offered a twenty-dollar gift card for their participation and to offset travel expenses. They were given an additional ten dollars for each qualifying person they referred and who completed the study; this is called chain referral or snowball sampling (Holloway & Wheeler, 2010). Only one participant was recruited through snowballing.

Outsider

In preparation for doing this study with young Black MSM, the researcher recognized that they are an outsider to this community because of a number of factors including, but limited

to, age, class, education, socioeconomic status and being new to the geographic area (Kauffman, 1994). Because the participants are (a) young Black men, (b) with substance use or HIV histories, and (c) under the age of 35, there was definitely sensitivity about not giving the impression of having an outside researcher just come in, take what data is needed, and leave the community and study population feeling taken advantage of. From previous conversations with key agency personnel, it seems that this behavior is part of the history of researchers who work with community-based agencies. These concerns were discussed and the researcher has promised that they are not only interested in the initial study, but that their interest is personal and goes beyond just the immediate academic need. The long-term plan is to stay connected to these agencies and continue to find ways that we can work together to decrease substance use, HIV transmission risk and improve the health and lives of young Black MSM.

Interview Locations

Although all of the participants were recruited through community partners, about half of the interviews took place at other outside locations chosen by the participant, in collaboration with the researcher. Spaces chosen were private, safe, and quiet so that they interview could be recorded and note taken by the researcher. At all times, care was taken to maintain privacy and confidentiality of participants throughout the interview process, including offering participants the option of using a pseudonym, but most chose to use their real first name. This spoke to the researcher's ability to make the initial connection with the participant, engage with them fully so that they felt comfortable from the onset of the interaction. Relational ethics serve to remind the researcher to respect participants as well as the community where the research is conducted while the researcher pays close attention to his or her actions and interactions on others. All participants were informed that the researcher was a Mandated Reporter and was required by law

to report any financial, physical, sexual, or other types of abuse, neglect, or other imminent risk of serious harm, either observed or suspected. This was not a problem during any of the participant interviews.

Data Collection

Engaging in research is an activity that requires careful consideration at the outset. The researcher first identified the problem to be studied and then determined the appropriate method suited for the study (Creswell, 2007). A literature review was done to examine existing literature and identify any gaps in the literature related to the topic or intended research problem (Creswell, 2007). The research problem usually guided the researcher in an approach for gathering data, which was achieved, through exemplars such as interviews and observations.

Procedures

Riessman (1993) does not acknowledge a specific standard set of procedures for analyzing the data but offers a choice to researchers. Explanation of the study and informed consent was obtained first. The researcher got approval to waive signatures of adult participants, using an Information Sheet (APPENDIX D), to protect their privacy and anonymity. Minor participants were required to sign an Informed Consent (APPENDIX E).

For descriptive purposes, demographic and behavioral data was collected from each participant prior to the interview on the Demographic Sheet (APPENDIX F) and included the following: age, age of initiation of sex, identified race, identified sex, sexual orientation, zip code in San Francisco, year of HIV diagnosis, relationship status, educational level, school/employment status, substance use, sexual behaviors while under the influence of drugs or alcohol.

The researcher developed a set of Interview Questions (APPENDIX G) for the purpose of guiding the semi-structured, recorded interviews. The research problem, substance use and HIV risk behaviors among young Black MSM, guided the development of the interview questions. The questions in the Interview Guide kept changing over time based on the significant emerging themes that were developing during each of the interviews. In other words, the Interview Questions used during the initial pilot study was very minimal compared to the final Interview Questions that were used for the last few interviews. It's important to note that this is just an interview tool and that the actual interviews were actually guided by the participant's responses. Given the sensitive and personal nature of the investigation, all sessions were audiotaped and notes made during and after each session. It was important to establish a seriousness of purpose from the onset but also be curious about the participant's experiences and life world that they were sharing with the researcher (Holloway & Wheeler, 2010; Kesselring, Chesla & Leonard, 2010).

In order to facilitate a degree of comfort with the researcher, the interview began with general reflective questions about living as a young Black MSM, and then moved to more specific, sensitive questions about substance use and HIV risk behaviors. The in-depth interviews lasted no more than two hours to reduce the possibility of emotional stress following a lengthy interview. Interview questions explored the participants' upbringing as it relates to being a Black MSM, substance use history, and sexual HIV risk behaviors. During the interview, the researcher remained respectful of the participants' emotional state and allowed the participant control over the duration of the interview. The participants choose to not answer any questions that they were uncomfortable answering and the researcher reminded them of this throughout the interview. Participants were also made aware that they could end the interview at any time or choose not to

be involved in the follow-up interviews. The researcher's notes further guided the exploration of other significant factors that came up in the interview conversation. As with other types of qualitative methods, data collection and analysis occurred simultaneously, moving back and forth, refining interview guide questions was an iterative process (Holloway & Wheeler, 2010).

Data Analysis

Interviews

Narratives are obtained through interviews. One-on-one or personal interviews were used to obtain in-depth descriptions of participants' experiences related to the research problem (Cresswell, 2007). One-on-one interviews were conducted in person at community-based organizations, UCSF, private homes, and the public library. One-on-one interviews were better for collecting personal and sensitive data, particularly in a population of young Black MSM with substance use and HIV sexual risk issues. A personal interview created a safe, private space for a participant to share openly about their experiences while also respecting their confidentiality and preserving anonymity.

The Interview Questions (APPENDIX G) were semi-structured, containing broad, open-ended, non-judgmental questions to encourage participants to share their experiences and to allow themes to emerge that may not have otherwise been forthcoming (Holloway & Wheeler, 2010). The range of interview topics was narrowed in order to gather data specific to the research question.

Quality interview data was rich and reflected participants' experiences. The criteria for assessing the quality of interview data were: (a) the amount of data from the interviewee that provided rich, relevant and spontaneous answers, (b) interview questions that were short with

full, lengthy participant responses, (c) clarification of participants' meaning of important issues, (d) the researcher interpreted interview data simultaneously while conducting data collection, (e) the researcher validated his interpretation of the participants' answers while interviewing, and (f) the interview spoke for itself with trivial need for further explanation (Kvale, 1996).

In narrative research, the interview is the tale or the story (Holloway & Wheeler, 2010). The tale is not the experience itself but a representation of the experience as it is stored in the memory of the individual. The initial interview question was broad enough to trigger a long story, followed by additional questions from the researcher to develop the story. The storyteller determined what he wished to communicate to others or what he left out of the story. Illustrative quotes from the interview provide evidence for the researcher's interpretation of the narratives (Riessman, 1993).

Coding

As with other types of qualitative data, the researcher began coding narratives line-by-line, then chunk-by-chunk, and then paragraph-by-paragraph (Holloway & Wheeler, 2010). Preliminary coding of themes that are related to the research question and that resonated with the prevailing ideas described by participants was the primary focus of initial data analysis (VanDevanter et al., 2011). Coding meant marking sections of data, reducing it to meaningful segments, and giving labels or names to the segments (Creswell, 2007; Holloway & Wheeler, 2010). A code in qualitative research is a word or phrase that summarizes the essence of what is said or observed for a portion of data (Saldana, 2009). The data the researcher coded came from various sources including interviews, field notes, memos and observations (Saldaña, 2009). Coding was the most critical component of data analysis and was considered the foundation from which analysis emerged. Coding provides the link between data collection and the development

of the emerging themes; it was a way of defining what was happening in the data as the researcher attempted to understand what it meant. In addition, analytical memos and notes taken by the researcher are coded in the same manner and were coordinated with the codes from the transcripts.

Talk was “cleaned up” of disfluencies to render it easily readable (Riessman, 1993). Holloway and Wheeler describe this as identifying significant statements, formulating meaning, and developing clusters of themes to come up with the participant’s story. Restorying is the process of reorganizing stories into some general type of framework, placing them in a chronological sequence; this sets narratives apart from other genres of qualitative research data analysis. When all participants’ stories are linked together and analyzed, these exemplars or paradigm cases give meaning to the research problem (Leonard, 1989). Riessman (1993) sums it up this way, “by studying the sequence of stories in an interview, and the thematic and linguistic connections between them, an investigator can see how individuals tie together significant events and important relationships in their lives” (p. 40).

Note-taking.

This researcher took notes during the interview so that participants’ facial expressions, gestures, and interviewers’ reactions and comments were recorded (Holloway & Wheeler, 2010). After each interview, additional notes were made to capture the flavor, behavior and words of participants and concomitant thoughts of the researcher; this was not done in the presence of the participant.

Analytical Memos

Memos are a method for the researcher to engage in and analyze data early on that will assist in data analysis. Memos are described as a process used in qualitative research that allows

the researcher to write down thoughts and ideas about the data and emerging themes (Holloway & Wheeler, 2010). While there is no right or wrong way to write a memo, it is considered a learned skill of qualitative researchers that serves many purposes: (a) allows the researcher to engage in open dialogue about the data with themselves; (b) offers explanations and definitions of properties and characteristics while clarifying the processes; (c) encourages the researcher to analytically distance themselves from descriptions about the phenomenon to conceptualization; (d) allows the researcher to record thoughts and feelings about the direction the data are moving into for further data collection and analysis; (e) aids in coding and categorizing data; (f) provides a space for analytical ideas; (g) identifies patterns and properties in general and specific research situations; and (h), is instrumental in generating theory. Memos keep the researcher actively engaged in the data while making constant comparisons, constructing categories, or simply writing whatever comes from the data for immediate use or use in the future as the themes emerge.

Reflections and Reflexivity

This researcher reflected on his project and adopted a critical stance to it, thinking about how the research could be improved, extended, or illuminated from another angle (Holloway & Wheeler, 2010). The description of the researchers own location in the research is called *reflexivity*. Reflexivity was ongoing through data collection, analysis, interpretation and writing the research report (Holloway & Wheeler, 2010). As the main tool of the research, researchers are part of the phenomenon to be studied and must reflect on their own actions, feelings, and conflicts experienced during the research (Holloway & Wheeler, 2010). The researcher must critically reflect on his own preconceptions and monitor their relationships with the participants and his own reactions to participants' accounts and actions (Madden, 2010). By adopting a self-

critical stance to the research and his role, relationships and assumptions, the study became more credible and dependable, enhancing the overall quality of the research (Holloway & Wheeler, 2010). The voice of the participants and the illumination of the phenomenon under study should always have priority.

Scientific Rigor

Debates have long centered on quantitative epistemology and methodological issues of qualitative research, more specifically, the difficulty of establishing validity (Whittemore, Chase & Mandle, 2001). According to Whittemore and colleagues, quantitative and qualitative research methods seek to measure different outcomes, and are therefore, thought to require different standards for assessing validity. Quantitative research is generalizable and objective whereas qualitative research is contextual and subjective and does not seek generalization. Although numerous terms and criteria have been debated extensively and remain contested, none have gained acceptance. Riessman (1993) writes that “traditional notions of reliability simply do not apply to narrative studies, and validity must be radically reconceptualized” (p. 65).

Assuring rigor in qualitative research seeks to determine if the researcher practiced thoroughness and competence in data collection procedures and reporting of study findings (Creswell, 2007). Creswell believes data should be collected from multiple sources such as observations or interviews and should be sufficient to substantiate study findings. Data provided quality and credibility to the study.

Validity

To validate study findings, the researcher returned to a couple participants and asked about emerging findings and gained additional clarifying information. The researcher also asked each subsequent participant about emerging themes, only if they came up from the client during

the interview. Whittemore and colleagues (2001) propose primary and secondary criteria to establish validity. Primary criteria are necessary for all qualitative research; however, they do not stand alone and are substantiated by secondary criteria. Primary validity criteria include credibility, authenticity, criticality, and integrity. Credibility assesses whether findings of the research are reported in a way that is believable to the reader. Authenticity assesses whether the meanings reflect or represent participants' lived experiences. Criticality refers to the design of the study and its ability to capture variability, use variability in data collection, explore negative instances, examine biases and evaluate evidence to bolster study findings. Integrity refers to the critical reflection and analysis of the data as the data move to interpretation.

Secondary validity criteria include explicitness, vividness, creativity, thoroughness, congruence and sensitivity (Whittemore et al., 2001). Explicitness refers to the ability to follow the interpretations of the researcher. Vividness refers to the thick description of the findings that moves the reader into the world of the participant. Creativity refers to the novelty of the design and flexibility of the research process while using imaginative ways to present data.

Thoroughness seeks to establish if the data have been adequately sampled, interrogated, and analyzed to provide a comprehensive read of the findings. Congruence seeks congruency between the question, methods, and findings, within what is presented, past and current research, and prior theories and in situations beyond what was investigated or applicability.

Summary

Understanding the role substance use plays and the HIV risk behaviors of young Black MSM may give insight and guidance to community-based agencies and healthcare providers in their efforts to meet the needs of this population. Both quantitative and qualitative studies relevant to the substance use and HIV sexual risk behaviors of young Black MSM are limited to

young White, non-Hispanic MSM. This researcher wants to give voice to the substance use and HIV sexual risk experiences of young Black MSM which is currently missing in the literature. Narrative methodology, with an understanding of feminist perspective, was the best way to hear the stories, write about these experiences, and fill the scientific gap in the current literature and minimize researcher bias. From this study, this researcher is hoping to eventually develop some type of intervention that might include substance use harm reduction strategies or HIV prevention education that racially and culturally appropriate to this young population. Despite the challenges of getting at the truth, utilizing narrative methodology is still the best way allow these young Black MSM an opportunity to tell their story. Their voices and what they have to say are important and need to be heard.

Substance use and HIV continue to have an increasing impact in racial and ethnic minority communities, especially among young Black MSM, despite national strategies, interventions, and programs. There is a need to develop interventions and prevention education strategies with targeted messages that are racially- and ethnically-appropriate for this population. Young Black MSM need to understand the relationship between substance use and how it influences their ability to make decisions about protecting themselves against HIV infection and other STIs. Expected long-term health outcomes are decreased substance use, decreased HIV and STI transmission risk in this population, improved health of young Black MSM, and decreased HIV/AIDS disparity.

Chapter 4: Results

NUMBER OF PARTICIPANTS	n	12
AGE (mean)		26
	13-17	NONE
	18-21	2
	22-25	4
	26-29	4
	30-35	2
SEXUAL ORIENTATION		
	GAY	9
	BISEXUAL	3
HIV STATUS		
	NEGATIVE	3
	POSITIVE	9
DRUG OF CHOICE		
	MARIJUANA	5
	METHAMPHETAMINE	4
	OTHER: CRACK, ALCOHOL	3
AGE OF SEX INITIATION (median)		15
AGE OF DRUG INITIATION* (median)		15
RELATIONSHIP STATUS		
	SINGLE	7
	REGULAR PARTNER	5
HIGHEST LEVEL OF EDUCATION		
	GRADE SCHOOL	NONE
	HIGH SCHOOL	6
	SOME COLLEGE	6
	COLLEGE GRADUATE	NONE
EMPLOYMENT/STUDENT STATUS		
	FULL-TIME	NONE
	PART-TIME	4
	LOOKING FOR JOB	1
	UNEMPLOYED	4
	STUDENT	NONE
	OTHER:SSI	2
CITY BORN*		
	EAST BAY	6
	OUTSIDE OF BAY AREA	5
ADVERSE CHILDHOOD EVENT		5

Table 1. Demographics

*missing data

Demographic Information

Twelve participants were recruited for this study. The majority of them (n = 8) are between the ages of 22 -29; the mean age is 26 years old. Nine of these men identified as gay and nine of them were also HIV-positive. Even though marijuana was the most frequently identified drug of choice, the majority of participants (n = 7) included methamphetamine as part of their drug usage. The median age for both sex initiation and drug initiation is 15 (information about age of drug initiation was not obtained on the first 4 interviews). Most of the participants (n = 7) identified as single. Equal numbers of the participants completed some high school (n = 6) and some college (n = 6). In terms of employment status, most were either employed part-time (n = 4) or unemployed (n = 4). Even though it appears that most of the participants (n = 6) are from the East Bay, this might not have been the case if this data were collected from the first interviewee. Only five of the participants spoke about adverse childhood events, including molestation (n = 1), sexual abuse (n = 1), and physical abuse (n = 3), including one with neglect and child protective services involvement.

Participants were individually interviewed and all sessions were audiotaped with notes made during and after the interview. None of the interviews lasted over two hours, most were around ninety minutes. The participants chose to answer all of the questions, with the exception of a couple of instances where the researcher saw that the participants looked too emotional or took too long of a hesitation. In those cases, participants were reminded that they had the option to not answer the question, which they accepted. They were also asked if they wanted to stop the interview and both times the participants declined and wanted to continue telling their story.

Field notes regarding recruitment

The first thing that warrants mention is to highlight the challenges of recruiting participants for this study, as also noted in previous studies (Miller et al., 2005; Purcell et al., 2001). It took almost three years to recruit the twelve participants for this study. In looking back through the researcher's field notes, many of the entries reflected the disappointment and frustration by the researcher because of the following: (1) being stood up by participants for scheduled interview, (2) participants re-scheduling the interview, (3) not feeling as though the key agency personnel were really getting the word out about the study, and (4) that some potential participants were reluctant to want to share their "personal business" regarding substance use and HIV risk factors.

In one of the field note entries, regarding being stood up by participants for scheduled interview, the researcher noted that he had confirmed the 10:00am appointment time with the participant at 9:00am prior to driving over to Oakland. While pulling up to the designated meeting location, the phone rings at 9:50am and the participant says he is "*double-booked and needs to do something with his Dad.*" Here is the excerpt from the researcher's field notes: "*I was furious!! How could he do this to me? All the way over there for nothing. In the moment, I was able to remain cool and professional. Actually, I impressed myself with my behavior. I didn't want to burn this bridge. I need this interview...I am struggling and wondering if this is my life as a researcher dealing with this community, my community. In the back of my mind, I keep thinking that dealing with the white gay men could be so much easier. Maybe not.*" This last idea kept coming up throughout the entire time of the study as I witnessed my colleagues moving along in their recruitment of participants for their studies.

In another entry from the field notes, the researcher noted the following: *“It seems to be more of the same old thing...no shows. I’m sitting outside waiting for a participant to arrive. He’s late...if he’s even going to show up at all. This is by far, another frustration with doing qualitative work. The researcher is the tool. I have to be the one to make these contacts and to make these interviews happen. I have found myself becoming frustrated with the lack of responsiveness by these young MSM. I think my work could be so much easier with ‘lower hanging fruit’/gay white MSM. I pray for the wherewithal to stay committed and steadfast to my population of interest...but boy is it hard.”*

In addition, some of the interviews had to be rescheduled. One of the researcher’s field notes is titled, *Herding Cats*. *“I was (again) supposed to do two interviews and the one person rescheduled to Friday while the other doesn’t respond to my replies to his text messages. Boy, does this continue to be a challenge.”*

In terms of not feeling as though the key agency personnel were really getting the word out about the study, this may or may not be the case since the researcher does not necessarily have a way of knowing. On a couple of occasions, I was invited to come to groups and talk about my research project, but this never resulted in any participant immediately requesting to do an interview. In one of the field not entries, this is written: *“I’ve spent the last four years ‘building relationships’ and being a vocal advocate in this community and yet it feels that things have not yet quite popped off for me. I still feel a bit like an outsider, not being able to recruit directly, but desperately wanting to.”* I guess I am left to wonder how much of this is related to the mistrust of research, as mentioned by several of my participants during our time after the recording or does it have to do with the last concern below?

This last concern being that some potential participants were reluctant to want to share their “personal business” regarding substance use and HIV risk factors. I can distinctly remember thinking , as I was doing my initial doctoral coursework, that recruitment was going to be easy for me. Since I was not seeing or hearing about any research specifically about young Black MSM, I imagined that once the word got out and these young guys saw my flyers, they were going to be excited to have an opportunity to finally tell their story. That someone cared enough to want to hear their story. That has not been the case and on more than one occasion, potential participants voiced their concern about “personal business” regarding substance use and HIV risk factors. It was a sense that I could not be trusted with this kind of information. Why did I want to know and how was the information going to be used? There were concerns about the police and confidentiality/anonymity of their identity. Or was it also the participant’s perceived stigma by the researcher associated with disclosing information both of these sensitive topics?

In spite of these difficulties with recruitment, I am deeply honored and grateful to the young men who were courageous enough to share their stories and give voice to these narratives. Substance use and HIV continue to be a problem for young Black MSM and the only way to gain insight into their experiences is by them coming forward. We cannot create campaigns and programs without fully understanding their story, and ideally having them at the table to help create same. Their insights and perspectives are invaluable if we want to have an impact in this community. I encourage future researchers to continue to share their successes and failures regarding recruiting this hidden population.

Analysis Approach

The focus of the analysis was to better understand the role substance use plays in the lives of young Black MSM, describe their perceived risks for acquiring HIV, and explore the historical and social contextual experiences that have influenced them. In analyzing the interview transcripts, the researcher felt that it was paramount to simply share the words of each participant, the narratives, as a representation of the experiences of each of the individuals. It was important to respect each of their stories, verbatim, as expressed in the remainder of this chapter. The researcher wanted to share and highlight the voices of the participants as the main focal point. What is the story they are conveying and why is this important? How does this story help inform the science as well as what is wanted and needed in terms of prevention? Careful attention was taken to leave the complete context of each of the narratives intact, untouched and presented in its full entirety. Analytic commentary is presented to emphasize key aspects of each narrative and then to examine the stories collectively. These stories fill a gap in the limited scientific knowledge that is currently available about substance use and HIV sexual risk behaviors among young Black MSM. There are few qualitative studies that emphasize the real words of the participants and this is a critical component to understanding the experiences, first hand, so that effective prevention strategies can be created.

The participant narratives were analyzed through a contemporary feminist perspective. Narratives enabled the researcher to understand participants and gain access to their experiences through story-telling (Holloway & Wheeler, 2010). The interview was the story, a representation of the experiences as it was stored in the memory of the individual. Feminist perspective, allowed the researcher to focus on inequality among masculine and feminine men, power relations, sexuality, marginalization and unequal treatment in relationships (Godfrey-Smith,

2003; Jensen, 2004), while also exploring new questions and analyzing differences in sexuality and sexual orientation among this population (Im, 2010). Feminism supports people having the freedom to be in the world just as they are, regardless of sexual orientation. Illustrative quotes from the interviews provide evidence for the researcher's interpretation of the narratives (Riessman, 1993).

All narratives were obtained through face-to-face interviews, allowing the researcher to notice non-verbal cues and gestures that often led to other questions. The researcher used a semi-structured Interview Guide to move through the interview, allowing participants to share their experiences. Every effort was made to ask broad, open-ended questions to trigger a long story; with additional follow-up questions from the researcher to develop the story. The interviews were mostly high quality. Only one participant struggled with keeping focused throughout the interview and the interview was completed in thirty minutes.

The interviews were transcribed by a transcription service and many of the transcripts had to be verified against the audio recording because of gaps and missing content due to the transcriber not understanding the speech patterns, choice of word, or street lingo used by the participants. Coding provided the link between data collection and the development of the emerging themes, the main ideas being presented through the actual narrative. The researcher began by reading and coding narratives line-by-line, then chunk-by-chunk, and finally paragraph-by-paragraph (Holloway & Wheeler, 2010). This first step consisted of having the researcher read each transcript carefully to become familiar with its content while coding for the main ideas in excerpts. Codes were marked in sections of the data to help the researcher reduce it to meaningful segments (Creswell, 2007). Words or phrases were used to summarize the essence of what was being said for a portion of the data (Saldana, 2009). The second step had another

member of the research committee also coded half the transcripts, and then all the codes were compared and contrasted until agreement was reached. The third step consisted of combining similar codes so that major assertions could be made about what was found in the data pertaining to our research aims. The fourth step involved revising and recombining these similar codes to formulate main narrative themes related to our research aims. The fifth step consisted of defining and naming the main narrative themes, as well as the overarching themes. Preliminary coding of themes related to specific research aims was the primary focus of the data analysis (VanDevanter et al., 2011). Finally, two other members of the research team read about half the transcript and went through this same process. The group discussed their themes that emerged and consensus was reached among the team.

Additionally, the notes taken during and after the interview to capture the words and thoughts of the participants, along with the analytic memos and field notes by the researcher, were coded in the same manner and coordinated with the codes from the transcripts. Significant statements were identified and clusters of themes developed related to each research aim. Thematic analysis involves the researcher interpreting the narratives meaning from the whole story. The narratives below provide exemplars for the deeper understanding of the issues being experienced by young Black MSM related to substance use and HIV risk behaviors. It's their story, in their own words.

Preliminary Analysis

In initially examining the substance use and HIV experiences of young Black MSM, the preliminary analysis of the pilot study data highlighted a number of issues that helped in the development of subsequent interview guide questions. This initial, preliminary data helped guide the understanding of issues relevant to this topic. The narratives are from the first 4 young Black

MSM, all HIV-positive, who were recruited for this dissertation study. The themes that emerged from the narratives described an across-case experiential trajectory of all of the participants, beginning with (1) *social, environmental and insecurity (homophobia & stigma) issues* (overarching theme), (2) fleeing to San Francisco because of this, and (3) *benefits of methamphetamine for numbing, masking feelings and coping* (overarching theme). In other words, participant-after-participant described the same kinds of issues in the narratives of their stories with very minimal variation. It was surprising to this researcher that the collective narratives across the group were so similar. However, that also supported the validity of the findings and highlighted significance places in the trajectory that prevention efforts need to be targeted that specifically address the needs of young Black MSM.

Overarching Themes

The findings from the preliminary analysis of the initial transcripts revealed two overarching themes related to the story narratives of the young Black MSM. The first three narrative themes, described more fully below, are as follows: (1) issues with family because of sexual orientation, (2) early exposure to drugs within their family, and (3) leaving home, moving to San Francisco and surviving homelessness relate to an overarching theme of *social, environmental, and insecurity (homophobia & stigma) issues*. This encompasses the acknowledgement of the multitude of factors that contribute to initial substance use for young Black MSM, starting with feelings of not being loved, accepted and welcomed by their family because of their sexual orientation (social). This is then coupled with early exposure and use of substances with their family (environmental) and then later having to navigate the challenges of relocation to a new city, figuring out how to survive on their own, and dealing with the challenges of being homeless (insecurity). For this paper, insecurity is defined similarly as

described by Merriam-Webster (2016) as “*the state of being open to danger or threat; lack of protection; uncertainty or anxiety about oneself.*”

The remaining six narrative themes, also described more fully below, are as follows:

(4) methamphetamine exposure, prevalence and access in San Francisco, (5) drug use for emotional numbing, (6) drug use for sexual enhancement, (7) transactional sex, (8) youth sex power, and (9) sense of resignation about HIV diagnosis, all speak to the *benefits of methamphetamine for numbing, masking feelings and coping*. In other words, the young Black MSM in this study are discovering that this substance, methamphetamine, helps them deal with the issues and struggles they face in dealing with their life on the day-to-day basis. Albeit ineffective in the long run, this researcher must wonder if there is not some short-term benefit to using this substance, at least in the minds of the young Black MSM, to help get them through these difficulty experiences.

The participant narratives below fully highlight each of the nine themes that emerged during preliminary analysis. The narrative themes and the overarching themes are summarized:

NARRATIVE THEMES	OVERARCHING THEME
(1) issues with family because of sexual orientation (2) early exposure to drugs within their family (3) leaving home, moving to San Francisco and surviving homelessness	Social, environmental and insecurity (homophobia & stigma) issues
(4) methamphetamine exposure, prevalence and access in San Francisco (5) drug use for emotional numbing (6) drug use for sexual enhancement (7) transactional sex (8) youth sex power (9) sense of resignation about HIV diagnosis.	Benefits of methamphetamine for numbing, masking feelings and coping

Table 2. Preliminary Themes

Narrative Themes

Issues with family because of sexual orientation include being stigmatized due to homophobia, along with having to deal with rejection, judgment, discrimination, and lack of acceptance because of their homosexuality. This participant describes feeling of not being able to be himself as a young Black MSM because of this father's religious beliefs.

P3: *I wasn't really able to express myself at my home. I wasn't able to have a boyfriend or anything like that. Yes, after coming out to my father, it was just like I had nowhere else to go. So, I had to go into foster care, and I was staying with my father at that time. Because of his religious beliefs. So, he was like, "Being homosexual, you can't stay here, your brothers will catch onto it, pick it up, because they look up to you, and I don't need that," and he just kind of -- we just left it from there. I ran away.*

In addition, there is also *early exposure to drugs within their family*. The participants shared about their own early drug use initiation by other family members. The impact of this early exposure probably impacts how they use substances in later years.

P3: *I started drinking when I was 11. Dad was just, you know, "Here, you want some?" So, he would let me sip on his beer. He let me have half of his Jell-O shot one time. It was the first time I've ever gotten a buzz.*

P1: *I would use it [drugs and alcohol] on a not really everyday all day, but I would be using this stuff. Then, I started hanging around with different family members who used it all day, every day. That changed my routine of using it.*

All of the initial participants talked about *leaving home, moving to San Francisco and surviving homelessness*. This move is motivated because they were not accepted in their homes because they are homosexual. Once there, they are doing all that they can to get their basic needs met for food, clothing and shelter, and in this case drug use and not using a condom is often times a part of this experience by those that they encounter.

P4: *I found a lot of the guys my age were going through the same thing. They're looking for a place and like drugs are kind of included in your housing, whether you want to or not, and no one would really tell you if they were positive or not. Yeah, at the time, I was using [drugs]. Like every day, like kind of as a way of*

life I guess. I only did it on condition so I could get a place, because I was not trying to sleep on the streets, and yeah, if I had used a condom probably I wouldn't have gotten it [the place to stay]. I probably would have been told I had to go the next day.

This participant shared about the challenges and struggles of being in a new city and not knowing anyone else, and wanting to be himself, so he survives the best way he knows how: doing sex work. This is, in a sense, being forced to do survival sex.

P2: *What brought me here is I wanted to be somewhere where I felt I could be myself, and San Francisco is very open-minded, liberal, gay friendly. Because I came here by myself, no family here, didn't know nobody here in San Francisco. So, being that I'm a new person in San Francisco trying to survive and live, I was doing sex work mainly for survival reasons... to have a place to lay my head at night whether it be in a hotel room or somebody else's house or SRO [single room occupancy], what have you. I was just mainly doing it for survival, to have money... because I was new to the city and was trying -- and was doing it as a way of survival to keep from being homeless and to have money in my pocket. So, that's why I was doing it.*

Moving to San Francisco and engaging in drug use also brought a heightened awareness of people living with HIV. With substance use though, HIV awareness and protection were less of a concern this this participant.

P1: *That's when I moved to San Francisco and started to hear about people with HIV and I knew that in the gay community there was popular and stuff, but that didn't -- by me getting high all that went in the back -- out the window.*

The study participants talked about and described the theme of *methamphetamine exposure, prevalence, and access in San Francisco*. Methamphetamine use has already been clearly noted as a major problem among the dominant gay population in the city. This drug is contributing to increased rates of HIV and other sexually-transmitted infections. It is important to note that most of the participants in this study were not fully aware of methamphetamine prior to arriving in the area. This participant also discusses the connection between sex work and methamphetamine.

P2: *When I came here [San Francisco], meeting new people and getting introduced to the whole crystal meth thing because I never heard of crystal meth until I moved to the West Coast. I met some other people that are sex workers and they had introduced me to the whole crystal meth thing and then meeting tricks that were into meth use as well. So, the whole peer pressure of I didn't want to feel like -- I didn't want to seem like I was a square. I didn't want to -- I wanted to be cool, or people to like me. I didn't want them to think I was boring...they tend to kind of push you or peer pressure you into experimenting, trying new things that you had never done before, and then, it just leads down a road of sex with no protection and just doing things that you wouldn't normally do if you weren't high.*

This participant further describes his experience of the methamphetamine prevalence in San Francisco. He also shares about this struggle trying to stay away from it and wonders if he will be able to do it. This speaks to the challenges that some young Black MSM have when wanting to reduce or abstain from substance use.

P3: *It's just everywhere in San Francisco, it's just everybody does crystal [methamphetamine]. It's more crystal meth out here. People smoke crystal more than other substances. At least the people -- well, a lot of people that I -- people that I know. Yeah, I think it's huge, it's huge and I'm trying to stay away from it, like I'm trying to, but it's just like everybody around me has either done it or is doing it and it's just like, am I next? Like will I be the next person to do it? Or will I be stronger and just fight it and just stay away from it?*

This participant shares about his perceived connection between HIV and crystal methamphetamine, as well as how that impacts HIV sexual risk behaviors, including this idea of “poz-ing” (attempting to infect someone who is HIV-negative). Other studies have previously documented the connection between substance use and HIV, but it has never been explained in this manner:

P4: *But a lot of people who have HIV in the city use crystal and it's been hard for me to find people who aren't really dependent on it. Yeah, I think the crystal scene in San Francisco is really -- that's another thing I'd also say. If someone uses crystal in San Francisco, they're practically HIV positive. Yeah, and it also coincides yeah, PNP [party and play] and BB, bareback. So, usually smoking crystal meth and you're not using condoms, and now, I understand that basically means that you're having sex with positive guys. Super risky sex, super risky sex, and super risky sex. I did some research on it and I found out a lot of guys in the*

city participate in “poz-ing” ... getting like an uninfected guy positive and it’s almost fetish.

The young men describes *drug use for emotional numbing* so that he can deal with the new living circumstances that he finds himself in. This is definitely an effective coping mechanism, short term, but certainly has long-term implications for young Black MSM.

- P1: *I didn’t have no clothes, nothing. It was miserable. I was feeling suicidal, but I didn’t want to kill myself. I was just like, “I’m tired.” I was just getting high just to deal with life, period.*
- P2: *It’s like numbing the bad feelings about having to even do sex work just to like have money to survive, to live everyday life. So, yeah, the whole -- kind of like going through the motions, but you do it because that’s your hustle, whatever, that’s your way of survival...they’re just a person, they have money, they’re a trick, a john to use.*

These young Black MSM discovered the *sexual enhancement* benefit of methamphetamine use, which often times allowed them to engage in sexual behaviors that they would not normally do (multiple sex partners, escorting, be submissive, forego condom) if they were not under the influence.

- P2: *Yes, it [methamphetamine] makes you -- that’s the thing about it too, you can have sex over and over again. It’s like it’s not just like a five-minute high. It’s lasts -- it can last for days... it makes it where you can go on and on to the next person, on to the next, next, next, it makes, because it sexually makes you horny.*
- P3: *Yeah, it [methamphetamine] makes you -- it makes me a bit more horny I guess, or it makes me want to work, like want to do stuff. I used to escort, so, sometimes it would make me like get in the mood for that. Yeah, it does make me a bit more raunchy because a lot of guys here, they are a lot more into porn star style sex. It [methamphetamine] makes me commit to someone’s demands a bit more...it makes you just want to have sex, just want to have sex, and want to have sex, and in a city like this [San Francisco], you can go through a lot of people really fast.*
- P1: *Well, basically, when I use drugs and I have sex, most likely I’m not going to want to use a condom. Most likely, I’m going to do some type of fetish. Some inappropriate behavior that could be harmful to either me or the partner because I’m on drugs. So, every sexual encounter I had was unsafe, because I wasn’t in the right mind frame. I just wanted to get high. That’s always on my mind. It*

[methamphetamine] kind of made me feel sexy in a way. It made me feel like a porno star. I could just go for a long time.

In addition, the participants describe engaging in *transactional sex*, also referred to as male prostitution. In a sense, the drug allows for sexual escape, so that they can do what they need to do to get the money. Here are a few further insights into this behavior:

- P1: *I'd seen people getting money in a fast way. They were getting high. It really looked like they was living the life. I looked at them and I looked at drug dealers. I looked at different ways to get money, but this way -- I didn't care what I had to do. It was coming real fast. I jumped into that which was male prostitution. When I was using drugs and didn't have the money to get it, eventually the drugs started running me. I was just doing anything and everything with different people with different ways on how to get high. Money was coming in. I was like, "Oh man, this is the life." It was like, "Oh man, this is what I'd seen in those movies Paid in Full and Boyz n the Hood and all them. This is it.*
- P3: *The more you would do, the more money you would get, and at that time, I needed the money. I really needed it.*
- P2: *When you're high, sex is more, I guess intense and enjoyable, and I guess, a lot of times use it to escape the reality of being that I was doing sex work, not doing it because that's what I wanted to do it, but doing it for survival, for money, is like I guess, it makes you forget about the person that you're with, even though it might be someone that you really don't want to be with, but you're doing it because they going to pay you for the services.*

Finally, one participant shared about this idea of *youth sex power*. It's the idea that young Black MSM have some power over the older men who want to have sex with them. Interesting to also note from this narrative that older men were also the only ones going after this young man.

- P3: *I spread like a wildfire. I was hot. I'm young, and then, all the older guys wanted me. So, I was just like -- those were the only guys that tended to approach me, and I was just like, forget it, you know, why not? It was just to easy to have sex with people, like you know, it's just like, here it is, you know what I'm saying? Hit it and quit it, and then, you never really have to see that person again.*

Finally, because of the substance use, the participants have a *sense of resignation about HIV diagnosis*. They are apathetic about acquiring HIV and it is almost as if they wanted to get

infected. Or, does this speak to the powerful influence of methamphetamine and the ability of the drug to bypass reasonable concern for self-care and self-protection among young Black MSM?

P3: *When I went to go get tested, my results came back positive. Was I shocked? Not really, because I had worked at a bathhouse [sex club] previous. I was making pretty bad decisions, I guess, when I was working at the bathhouse, because I was a dancer there. I was a stripper, and then, that kind of led to drugs and alcohol and clubbing and just pretty much partying. Like I prepare myself for it by telling myself, "Oh, it's possible, it's bound to happen."*

P4: *So, the next day, I went to [place to take HIV test] and, what do you know, it says that I was positive and she asked me if I was all right and I said I was all right, but I kind of knew that I was positive.*

Analysis of Research Aims

After completion of the preliminary analysis, the research aims were slightly modified and the research guide was updated accordingly. The revised three aims were clearer and allowed for recruitment of both HIV-positive and HIV-negative participants to further explore the experiences of young Black MSM. Similar to the aims of the preliminary interviews in the pilot study, the modified aims were as follows: (1) *understand the role substance use plays in the lives of young Black MSM*, (2) *describe the perceived risks for acquiring HIV among young Black MSM*, and (3) *explore the historical and social contextual experiences that have influenced young Black MSM*.

Over the next several months, an additional 8 participants were recruited (five HIV-positive and three HIV-negative) and further analysis of the research aims was completed. The subsequent participants had similar experiences as the participants in the preliminary analysis, as well as offered some expanded insights about the experiences of young Black MSM. Those narratives will be highlighted in the remainder of this chapter. The stories, taken in totality, from all the 12 young Black MSM, both HIV-negative and HIV-positive, add a broader perspective related to the area of interest. The themes that emerged from the narratives of their stories, along

with the overarching themes, are summarized in Table 3 and more fully explained in the remainder of this chapter. Presented first are the overall narrative summaries about the key findings of this study related to the research aims.

Summary of Key Findings for this Study

Here is a summary of the four key findings related to the overall research aims of this study that emerged from the narrative stories of the young Black MSM:

- 1) “There was a lot going on in the homes of these participants.” Almost all of the young Black MSM discussed early substance use exposure in their family, including parents who were also drugs. The young men shared about broken family structures, including abuse and neglect. These social and environment factors contribute directly to their own early substance use initiation (median age 15), as well as early sex initial (median age 15), at times with parents providing the drugs. Mean age for participants is 26.
- 2) Over thirty years into the AIDS epidemic, stigma and homophobia continue to be an issue for these young Black MSM. Most of the participants were either kicked out of their family homes, asked to leave by their family, or wanted to get away from their family so that they could be themselves. This is blatant discrimination. Most came to San Francisco as a safe place, only to face homelessness and having to figure out how to survive on their own. This creates a sense of insecurity.
- 3) With the prevalence and exposure to methamphetamine in the San Francisco, young Black MSM discover the benefits of this drug for numbing, masking, and coping with everything from being gay, gay sex, dealing with peer pressure, and for sexual enhancement and survival sex. These issues act as drivers for methamphetamine use as an ineffective coping mechanism.

- 4) Almost all the young Black MSM had some knowledge and awareness about HIV prior to arriving in San Francisco; most were testing regularly every three months. Once under the influence of methamphetamine, the participants don't care about condoms, nor do they have the ability to negotiate condom usage with their partners. There is a sense of anticipation, resignation and acceptance about acquiring HIV; HIV risk reduction apathy.

AIM	NARRATIVE THEMES	OVERARCHING THEME
<p>1. Understand the role substance use plays in the lives of young Black MSM</p>	<p>(1) early substance use exposure and initiation in family (2) for coping with gay sex and being gay (3) peer pressure in new community to fit in with others (4) exposure to lots of methamphetamine in San Francisco (5) to numb feelings (6) sexual enhancement and survival sex.</p>	<p>Social & environmental issues Benefits of methamphetamine for numbing, masking feelings and coping</p>
<p>2. Describe the perceived risks for acquiring HIV among young Black MSM</p>	<p>(1) were testing regularly for HIV (2) knew/didn't know about HIV before arriving to San Francisco (3) don't care about condoms when under the influence (4) inability to negotiate sex and condom usage (5) sense of anticipation, resignation and acceptance about acquiring HIV.</p>	<p>Some awareness of HIV Poor condom negotiation, particularly when under the influence HIV risk reduction apathy</p>
<p>3. Explore the historical and social contextual experiences that have influenced young Black MSM.</p>	<p>(1) broken family structures, some with parents on drugs (2) adverse childhood experiences (ACE) including neglect, molestation, sexual abuse and physical abuse (3) stigma, racism and homophobia.</p>	<p>Disrupted family structures - with parental substance abuse Abuse and neglect Discrimination</p>

Table 3. Summary of Research Aims and Themes

Aim 1: Understanding the role that substance use plays in the lives of young Black MSM**Overarching Themes**

Similar to the preliminary analysis, there are two overarching themes that emerged from the narratives related to the first aim, *understanding the roles substance use plays in the lives of young Black MSM*. The first narrative theme, (1) early substance use exposure and initiation in family, described more fully below, relate to an overarching theme of *social, environmental, and insecurity issues*. Young Black MSM are exposed to substance use in their family, with family members who are also using drugs. With their own early initiation to substance use (median age 15), they discover *the benefits of methamphetamine for numbing, masking feelings and coping*, as it relates to the stories of the remaining narrative themes for this research aim. The remaining five narrative themes, also described more fully below, include: (2) for coping with gay sex and being gay, (3) peer pressure in new community to fit in with others, (4) exposure to lots of methamphetamine in San Francisco, (5) to numb feelings, and (6) sexual enhancement and survival sex. As mentioned, these themes address the reasons that the young Black MSM describe using substances in their lives beyond their early exposure and initiation.

Narrative Themes

Most of the narrative themes that emerged from the stories of the subsequent participants were identical to those discussed in the preliminary analysis. Participants continued to share about *early substance use exposure and initiation in family*; their parents and caregivers are addicted to drugs. This participant shared about early substance use as well as introduction to pornography:

P6: *Man, I started smoking weed when I was 12. I started drinking alcohol when I was 13...And not only that, drugs really run in my family. My dad was an addict of cocaine... My thing was being introduced to pornography at a really young age, being introduced to drugs. (HIV-positive)*

This participant witnessed drug use by parents and grandmother, along with parental violence.

P11: *Well, I was around my biological mom a lot of the time. I wasn't around her a lot of the time, excuse me. But whenever I was, I witnessed her do drugs. And my mother has been on crack cocaine for the last thirty-something years. She should be almost 50. So, I guess she was on crack when I was born. So, you know, a crack baby... But growing up I used to see her do it and just seeing her and my father fight a lot. I just watched all the downside of drugs, of drugs of her time, what they did to her and how they made her view her kids and everything... Arguing over drugs and just what drugs did to them, how it brought them down... Yeah, he [Dad] was a heroin addict... I was in the system [Child Protective Services] the first nine months of my life... She [Grandmother] would ask me to light that [marijuana joint] on the stove and hand it to me. So, that's just where I picked it up one day and lit it. And she said, "Oh, you want to be grown, huh? Well, go ahead and smoke it." And that was it and that's how it started. And then she said when I was getting high, "I'd rather you smoke it here with me than smoking it out and somebody putting something in it." So, I guess she was just trying to protect me. (HIV-positive)*

The participants also talked about using substances *for coping with gay sex and being gay*. These participants (one HIV-negative and one HIV-positive) share about how they bottom (be the receptive anal partner) when under the influence of drugs.

P5: *But yeah, if you want to fuck me I've got to be high. But I'll fuck you and we don't have to be high, something like that. Really it's just the effect of the drugs and my attitude....It [methamphetamine] makes you want to bottom. It makes you feel sexy. (HIV-positive)*

P10: *I know from when I was a bottom alcohol played a big role because it helps your body calm down and then you don't feel like a lot of pain or whatever. And it's like it keeps you amped or whatever...It keeps you revved up, turned up. Yeah, it keeps you turned up. The same thing with smoking weed or whatever, the weed will make you horny and shit. You'll be like turned up. Do you know what I'm saying?... So, I'll start drinking and we'll start smoking and pop our pills [ecstasy] while we smoke and start drinking or whatever, and that make your sex awesome....They say porn kills relationships or whatever or some shit or whatever. I guess so or whatever. But with me it's all about your imagination. And with me pills mixed with liquor make me get really imaginative. That's what turns the sex. It makes it into like a movie kind of. You can kind of make it go where you want it to go. (HIV-negative)*

This participant describes the connection between friendship, dating, sex and substance use. In his experiences, they all seem to be tied together.

P12: *When I'm talking to someone I'm not really asking them, "What type of drugs do you want to do?" It's more so I'm talking to them trying to either be their friend or trying to date them. So, if you're trying to date them then it's like, oh, you need sex. And to have good sex you've got to have the drug included. So, that's how I get caught up in the drug culture. (HIV-negative)*

In this narrative, the participant describes how substance use allowed him the freedom to explore gay sex and his sexuality.

P8: *I mean with [new boyfriend] and the drugs I kind of like -- it was the time for me to explore like what it means to be kind of gay...It was just like I didn't even know what that meant and tried to explore that and then also kind of like finding this new drug, which kind of made it easier as far as like -- I don't know. It just like made the whole sexual exploration easier for me I guess...It [methamphetamine] puts me into a different sexual space. ..Maybe it's like getting rid of the shame of gay sex...I then put myself in a situation where it's like, "Hey, it's okay to explore. It's okay to like explore like sexually. So, yeah I guess the drugs allow me to put down my inhibitions. I put down my walls and then explore (HIV-positive).*

Substance use is influenced by *peer pressure in new community to fit in with others*. The first participant shared about wanting to be in relationships with others when he wasn't under the influence, however, that would mean he would be asked to leave by the people he was hanging out with.

P5: *I always wanted them to see me when we're not high. I mean I wanted for them to know that you could hang out with me and you could take me public places... But for them, I mean they can have no feelings. I mean they can like totally be nonchalant and say, "Okay. Well, all right, deuces. See you later." (HIV-positive)*

This participant describes hanging out with someone, only to later discover that he is a drug dealer. He shares about the connection between sex and substance use.

P8: *He slowly like revealed to me he was a dealer and I don't know. I just adopted his lifestyle because I was there. I moved in after like four months of meeting him.*

We started dating and then moved in soon after. Yeah, I mean I just kind of got stuck at his house just like doing drugs because they were there. And then I slowly stopped going to work and then eventually just didn't go and got fired... "Hey, these are people that I'm meeting to like hangout and these people are like sex and drugs." It just kind of went hand in hand... And then like it's weird because I did slowly develop a relationships with people and then got used. It's hard for me not to go back into using every day... We would have sex and then use or just use to have sex...it just kind of went hand in hand I guess. (HIV-positive)

This participant is more social and outgoing when he is using and drinking, people tend to like him better when he is drunk.

P10: *Like I'm more sociable and more interactive if I have something in common with the people I'm around and that's usually drinking because I like to smoke, but I don't like to smoke all the time. Now, you can always pass me a joint and I'll be like let me hit this or let me go over here and let me hit it or whatever. But drinking like socially with people, it makes me more fun I feel because I think I'm very like I can be fun. Let's just say I'm more fun when I drink. I'm more -- I'm funnier. I make jokes and stuff I guess. People have told me they like me more when I'm drunk. I get that a lot. Yeah, they just say I'm more talkative, that I'm more fun when I drink a little bit. (HIV-negative)*

This participant describes meeting his new people through social media and how substance use is a part of that experience. Again, it's the idea of participants just going along with the flow of the people that they meet.

P12: *I just recently moved to California...I'm from the South and it's very country, so to move to a city is very different and that's where I notice where I am not as in control of my actions as I thought I was because it's a challenge living in the city versus living in the rural country. ... So, if you're looking for a friendship or a relationship that might not be the place to go because online there is a lot of sex mixed with drugs because usually when I get a message it's some type of asking of like, "What type of drugs do you use?" And that's how I end up in situations and that's why I label myself a social user because like I don't that I crave it, but when I meet somebody if I'm all caught up into the energy and how they're treating me and how I'm feeling, then I kind of just go with the flow. And that's kind of scary for me..... I might be over here at the library and someone will come up and be like, "Do you want to smoke?" And they'll roll marijuana, but then sprinkle white stuff in there. And it's like even though I see them doing it -- oh, just because I have this friend to talk to or someone to socialize with, I'm going to engage... I think the drug use is definitely connected with loneliness. It has to be. (HIV-negative)*

This participant's new community is tied into the gay ball scene which serves as his new family. The family structure is a way for the underground community to take care of its members, many of whom were rejected by their families. Being part of a house doesn't necessarily mean you live with members of your ballroom family, just that there are parents who serve as mentors and guides to those newer to the scene.

P9: *It's a thing with the houses [ball scene], the house -- the gay community do a house thing. They follow all over the internet. There's a lot of things where a lot of the gay people go and do drugs. They meet. They have sex. It's like a gay -- how could I say it? I want to say it's like the Olympics, but it's like different sports; runway, vogue-ing, all kind of stuff they do. They do so much... It's your environment. It's who you run with. ... you run with somebody that do drugs, you're going to do drugs. (HIV-negative)*

Again, participants talk about *exposure to lots of methamphetamine in San Francisco*. The comments below illustrates the feminist perspective whereby the dominant gay culture, in this case White gay men, is in control of the young Black MSM because they have drugs and money.

P5: *When I first moved to California, I'd been here about a year. I was real promiscuous because I got introduced to crystal meth. And that's really what started it all. And I just got into a lot of like different stuff. I was just sleeping with different guys and I was sharing needles because I had never used a drug before.... I did that mainly out of a standpoint of, "Well, all these white guys, they're the ones with all the drugs and they're the ones with all the money." You know? They're the ones with the cars and stuff. (HIV-positive)*

P10: *I had to escort a little bit. It kind of made me a better person. It's like I'm not going to be homeless...and these older white dudes would pay me to escort, like be the boyfriend experience and they would pay me by the hour and that would pay for our rooms; pay for our rooms, our food, everything.... this freak White called. He wanted me to be his little boyfriend experience and he's going to pay me \$300.00 for an hour and all he wants to do is like probably suck me up or whatever. That's what I'm fixing to do...I'll come back with the money to pay for our room for a week." I sleep for two days and then anything come in while them two days I'm asleep, I've still got to do my dates, but I get to be up in the room. I'm comfortable. I'm chill. We're cool. We've got food and it was like that for a while (HIV-negative)*

P12: *I'm living here in the city where the drug culture is so heavy. It seems that being in a relationship is even more of a challenge because there's this extra entity in the midst, which is the drugs pretty much. It's very confusing to me because I was unaware of the amount of drugs that actually float around the city. So, I've noticed through my experiences I've gotten into situations that were I guess not very healthy due to the fact that I'm -- no knowledge basically of the drugs that's going on. So, I've been going to the AIDS Foundation to educate myself and to look for support through the groups so they can teach me about what's out there and how to use safely things to keep in mind as far as when you are out using...I never heard about crystal meth when I was in [another State]... . Here in the city is a drug culture because you see it every day. You can see someone injecting when you're walking around. You can see someone smoking. So, to visibly see it is way more of an impact than just hear about it. Because just to hear about it you can easily dismiss it, but when you see someone getting high and then the way they act after they get high it's like, "Oh, can I feel like that? (HIV-negative)*

Participants also share about using substances to numb feelings, as an escape from their current reality of being homeless, not knowing anyone, nowhere to go and to not be fully aware of surroundings.

P5: *And also it's [partying] like an escape. It's an escape from my situation, you know? For a minute I'm not homeless, like for a minute. (HIV-positive)*

P12: *I was homeless, didn't know nobody, nowhere to go or anything like that. So, as far as random sex and drug use, that definitely played a part of me being homeless for sure because you just want to feel comforted and feel normal. And sometimes that normal came with, oh, use the drugs with this person to zone out, to not really be fully aware of your surroundings definitely. That definitely played a part in it. (HIV-negative)*

Sexual enhancement and survival sex were also reasons that participants used substances.

Methamphetamine increases sex drive and allow participants to do things that they had only thought about.

P6: *I enjoyed it. I'd be lying if I said I didn't enjoy it. I did. And when you're doing certain drugs it increases your sex drive and certain stuff and gets your momentum up... I do know the experience of using drugs and having sex at the same time and how powerful that can be because you're doing some stuff that might have only thought about doing. You might not have the chance to experience it, but now you're turned up on these drugs and you're high. Now you can do anything. (HIV-positive)*

Methamphetamine lowers inhibitions, allows for experimentation, and heightens pleasure in pleasing a partner.

P8: *Yeah because I don't know what it is about the drug [methamphetamine], but it heightens sensitivity. At that same time kind of limiting the senses in other areas of-- but it's sort of selfless too. It makes it like a heightened pleasure in pleasing someone else more than sober sex because I feel like sober sex is more of like a give and. But yeah, meth is like -- yeah, it's more I get off on pleasing someone else...And then inhibitions are lowered where it's just like experimentation is like more acceptable...I'm more bold to ask for what I want. (HIV-positive)*

This participant shared about how substance use allows him to escort, having multiple sex partners without ever getting tired.

P9: *I was an escort. I used to be an escort, because we used to live on the street. Drugs makes sex easier. It's a way to relax. A way to not be so at ease... Substance use make you keep going. You can have, bust [ejaculate] one, bust two, bust three, bust four. Just get down on one person and go on to the next, that's what substance use do. That's how I do. It makes you -- you know, when you have sex you be tired you want to go to sleep, you be like, "Okay, I'm drained." No, you ain't drained. It's okay now... You see so many different people. It's just so much....That's what substance use is for. (HIV-negative)*

This participant shared about the connection between money, drugs and sex with a variety of people.

P7: *Sex with men is good because it's good sex because they give you money and crystal meth also. They give me crystal meth, have a good time...It's hard sex, older men, guy and a girl, straight girls. I have sex with older men...I have sex with older men for crystal meth. They give me sex for crystal meth and it's good... I have sex and good times, yeah. I get high when I have sex. I have sex. I get high and I have sex. (HIV-positive)*

Aim 2: Describe the perceived risks for acquiring HIV among young Black MSM.

Overarching Themes

There are three overarching themes that emerged from the narratives related to the second aim, *describing the perceived risks for acquiring HIV among young Black MSM*. The first two narrative themes, (1) were testing regularly for HIV, and (2) knew/didn't know about HIV before arriving to San Francisco, relate to an overarching theme that all participants had *some*

awareness about HIV. The next two themes, (3) don't care about condoms when under the influence, and (4) inability to negotiate sex and condom usage, reflect the overarching theme of *poor condom negotiation, particularly when under the influence*. And the final theme, (5) sense of anticipation, resignation and acceptance about acquiring HIV, is reflective of *HIV risk reduction apathy* among young Black MSM. All of these will be described in more detail below.

Narrative Themes

Almost all of the participants said they *were testing regularly for HIV* and it appears that the testing incentives were a factor for some of them. There is value for these young Black MSM to take the test and have an awareness of their HIV status, at least initially. Obviously, some of the participants do end up testing HIV-positive, but testing regularly was definitely not this issue.

- P5: *Yes. Yes, and so there were always incentives for taking an HIV test. If you take an HIV test or you get a \$10 Safeway card. Like, cool, yeah. So, I was always doing that. So, I always knew my status and stuff like that. But so I always knew my status and I was always up on it because I always looking for an incentive like getting a gift card or something, you know? (HIV-positive)*
- P6: *Every three to six months... I was going to get tested, but that don't mean I was using protection. (HIV-positive)*
- P8: *I went in for STD's just kind of regularly because three months before it was all negative... Yeah, it was just like my three months checkup because right before the summer started it was negative. So, yeah this was like the one time that I wasn't scared. I just felt like it was kind of routine for me. (HIV-positive)*
- P9: *I do testing whenever they want me to test. Like somebody said -- if it's for --If it's for incentive --I test now... I test any time -- any time they have incentive for money, I usually go test. (HIV-negative)*
- P10: *I test regularly. Even though I only have sex with my boyfriend, we get tested regularly just to make sure our status stays. We're always on top of our health to make sure we stay negative and all the stuff... You've got to make sure that if you say you love somebody, you're in love with them, you protect them and you protect yourself. That's how I feel. (HIV-negative)*

One participant was not as aware of testing in his home State [in the Deep South], but now that he's in San Francisco, he as has received more education, openness and awareness about HIV testing.

P12: *I hadn't gotten tested at all...But when I first arrived here [San Francisco] I got tested through the foundation and that was negative, but that was last year...When you have resources and education it makes, for me personally, it makes it easier for me to make a comfortable, confident decision. Being in [the Deep South], I wouldn't hear much about people getting tested. I'm sure people were because the disease isn't new...So, I enjoy being out here where you can get tested and you speak to people who have the virus because I go to an HIV awareness group. (HIV-negative)*

Participants knew/didn't know about HIV before arriving to San Francisco. These first couple of participants seemed to have some understanding about HIV, but it isn't quite accurate. More than likely this contributed to both of these young Black MSM eventually testing HIV-positive.

P5: *And I wasn't taking HIV seriously. I knew that people I was sleeping with were positive. I didn't care. I mean like they would tell me. They would say, "I'm HIV-positive. I want you to know that." And I was like, "Fine. Okay, whatever." And as I think about it now, it was real sad like the way I went about it. But, like I said, I thought I was immune to the disease really because like six months it went on. I mean like and I was still testing negative, you know? And I finally got that positive test and they told me. (HIV-positive)*

P8: *My roommate, he said he was undetectable and we didn't know we weren't supposed to have sex. We had sex and I just took the risk. I saw his medication there too, so I'm like he's probably undetectable. That's the only person I've had sex with...At the time I thought I knew about the risk factors I was taking, but I don't think I knew as much. I thought undetectable meant like you can't detect it at all, and that's not true. (HIV-positive)*

This participant was given information and education about HIV from a local gay youth center and has stayed HIV-negative because of it.

P9: *SMAAC is a gay youth center, like I told you...It's the LGBT youth center, Downtown Oakland. It used to be. Ain't there no more. They talk about everything: sex, condoms, everything. .. Yeah. All them are hookups, right then and there, sex hookups, right then and there. What you want. Boom, boom, boom. Everything...HIV, HIV, it's just high risk. All them places are very, very high, high, high, high risk ... Yeah. I stay HIV-negative because of SMAACs and*

because of -- stay HIV-negative because of SMAACs. SMAACs taught me. (HIV-negative)

This participant talked about not getting much information in his home State (the Deep South), but has gotten much more information as a result of being connected to an organization here in San Francisco.

P12: *The virus isn't new, but there wasn't a promoting of it [in the Deep South]. And here [in San Francisco] there's promoting for getting tested... And then also just the fact that at the AIDS Foundation they will leave stuff out like condoms and lubes for the taking for free. And it's like those little, little resources right there can start a little seed in my mind for like, "Okay. Well, look at that. Safe sex is a possible outcome for you if you choose to." It's all about the choice again, but the education was lacking pretty much [in the Deep South]. (HIV-negative)*

Most of the participants *don't care about condoms when under the influence*. This theme was prevalent for both HIV-negative and HIV-positive participants alike.

P5: *Now, usually when there's drugs involved you can forget trying to put on a condom because nobody is going to go for that. I mean because it's like oil in water. It doesn't mix. ...But yeah, I've tried it a couple of times. (HIV-positive)*

P7: *What's different is I just have sex with a guy high, crystal meth...Bareback, yeah. That's actually not safe sex, bareback, unprotected sex. (HIV-positive)*

P9: *My friends -- you do crystal -- crystal is a sex drug. That's where a lot of people get infected with doing crystal. They are really getting infected. Crystal is a sex drug. It makes you go, go, go. You get so horny you just be going for like 6 hours getting fucked. So, that's just ridiculous. And then the condom is gone and you out of condoms. "Fuck this condom," and you just keep going. Keep going. Keep going. (HIV-negative)*

P10: *I remember the stuff these older dudes were telling me, or they fed me this liquor and passed me the blunts and stuff, it would make me like really horny and then you don't be thinking about condoms. You're really not... Because you're high, you're drunk, you're feeling good. They're probably rubbing on you in the right way, touching on you and saying the right stuff in your ear and stuff. And then you're not thinking about no condom, especially if you're hammered, you know?... Yeah, weed and the alcohol and the pills play a big role because I'm not really horny all the time, but they make me horny and nine times out of ten I'm not thinking about putting on no condom.... If a condom is not readily available and ya'll are already in the heat of the moment, they're not fixing to stop in the heat of the moment to get no condom for you if it's not readily available. If it's not right*

in your pocket, why would you stop touching on me and doing that to go look for a condom? That's going to take three minutes. Now I done lost my woody. Now I'm irritated. Now I need more drink. Now I need another blunt to get back in the mood. I'm irritated. I'm going home. And that's how it be in the gay community. Gay people want it fast, now, and in a hurry. When it comes to drug-induced sex, it needs to happen fast. (HIV-negative)

This participant had some additional insights. It's almost like "don't ask, don't tell" in terms of one's STD or HIV status when under the influence.

P6: *Well, see, because when you're in the heat of the moment and you're on a drug, if you ain't got no condoms you just might decide to have sex raw or you might get with somebody and they tell you they ain't got nothing and because you're on a drug you just bypass the question altogether. "Don't even tell me nothing about your STD status. I don't want to know." There's people and I've been in situations myself like that where I just didn't care. (HIV-positive)*

This narrative speaks to the participant's sense of obligation to the person providing the drugs to them and then going along with having sex without a condom.

P12: *But nowadays since everything is so connected through the phone, a lot of people hook up through the phone ...So, usually those attachments come with, "Use drugs with me." And it's kind of -- it sucks for me because it's like I should be able to be strong enough to say, "Well, I don't want to do any drugs, but we could still kick it." But even that's a challenge because being around it you'll still be tempted, especially if they're like asking you to do it. So, that's where that peer pressure kicks in like, "Oh, it's okay. It's okay. We're fine. Let's just do it." And that's how I've ended being in situations as far as sex-wise where it's like doing activities without a condom. You know, "Oh, it's okay. It's fine. Let's just do it without a condom." And it's like, okay, you know, thinking that I have to say yes just because someone might be sharing their stuff with me. So, it's kind of like I feel -- is entitled the right word? I feel like I have to because they're doing something for me in a sense. Does that make sense?... So, penetration sex does scare me in a sense because like I don't want to catch the virus. But I do enjoy it, being submissive and a bottom to a boy. But I have to learn that it's not the top's responsibility to supply the condom. (HIV-negative)*

Participants have an *inability to negotiate sex and condom usage*. There is definitely a power differential in these narratives, particularly with older male sex partners. Young Black MSM really struggle with having the skills necessary to protect themselves.

- P5: *I've tried it a couple of time [condom negotiation]. Trying to just stick to and say that, "Yeah, I'm going to need a condom. I'm going to need you to use a condom." But it didn't work out because they ended up usually telling me that, "Well, you can leave then because I don't do that." (HIV-positive)*
- P10: *But it's when I'm with somebody older that pulls the reigns and be like, "No, little nigga, you fixing do like this." And I'll be like, "Woo! Okay, yeah this is what we fixing to do." It'll be a shift in power and it's like, I don't know. The freaky side in me like that... But if it's an older dude and they know what they're talking about and I feel it up in here, yeah then. They be like, "Nigga, we ain't using no condom, nigga. We fixing to do this right now." It'll be like -- it was like that for hella years when I was younger. Praise God I'm so glad I've like never ever caught nothing or whatever, caught no STD's or anything because I was with maybe five, maybe four older dudes that I was in serious relationships where I was having sex without condoms... we wouldn't use condoms, but they would tell me all this like. "If you're feeling wild you need to use condoms because not all motherfuckers ain't going to tell you like I'm going to tell you, because you know I care about you." ... I was young and dumb, stupid, dumb, sexy, stupid, full of cum, just high, drunk. (HIV-negative)*
- P12: *I was just going out at night to exercise. So, it was about 1:00 a.m. in the morning. I would have never thought that I was going to run into a boy, so I didn't have protection on me and stuff. I didn't have lube on me... Then I met a boy and the next thing you know he is trying to penetrate me. And it's like by then it's too late to be like, "No, no, no," because it's feeling good. But then at the same time that it's feeling good, it's like in the back of mind it's like I know I should have been more prepared because if I am going to be willing to just engage in some random sex outside that I need to be alert,, Because in my mind it's like if you're the top and you're going to do it, then since you want to put your thing here that you would want to wrap it up. But no, it's totally up to me to speak up because every situation where I haven't it's always been raw sex. (HIV-negative)*

As discussed in the preliminary analysis, participants continued to speak about a *sense of anticipation, resignation and acceptance about acquiring HIV*. Among young Black MSM, there is a sense of *HIV risk reduction apathy*, where participants are not going to great lengths to avoid becoming HIV-infected. It's almost an acceptance of the inevitable, based on their behavior.

- P5: *When I think about it I did want it [HIV]. I was trying to get positive. Yeah, I was trying to get it. Yeah, that's what it was because when I got here I couldn't get any services because all of the services you have to be HIV-positive. (HIV-positive)*

- P11: *I've worked in the field with HIV so long that I practically know everything there is to know about HIV except when they come out with a new medication. So, me knowing that and understanding how it works, I just never really let myself go under because I knew that one day this day would come. So, I'd just rather embrace it than push it away. (HIV-positive)*
- P12: *And just through listening to different people's stories and tell their truths so freely, it empowers me to, you know, if I am going to use not to be really shamed for it because I have a lot of examples at these support groups that explain the highs and lows, but they're still here in my eyes. It's like you're still here, so like regardless of if it became addictive or if it's just something that's light use that you pretty much -- they're still here, so it's not a death sentence kind of. And that's how I'm starting to look at HIV and AIDS as well because I have participated in risky behavior....I was very afraid before, but now due to education I'm not as nervous as I was before because I see that there will be help for me if that does happen. (HIV-negative)*

Aim 3: Explore the historical and social contextual experiences that have influenced young Black MSM.

Overarching Themes

There are three overarching themes that emerged from the narratives related to the third aim, *exploring the historical and social contextual experiences that have influenced young Black MSM*. The first narrative themes, (1) broken family structures, some with parents on drugs, relate to an overarching theme of *disrupt family structures - with parental substance abuse*. The second narrative theme, participants shared about (2) adverse childhood experiences (ACE) including neglect, molestation, sexual abuse and physical abuse, relate to an overarching theme of *abuse and neglect* experiences in the lives of young Black MSM. And the third narrative theme, (3) stigma, racism and homophobia have led to various forms of *discrimination* for the young Black MSM in this study and will be discussed in the narratives below.

Narrative Themes

The participants talked about their *broken family structures, some with parents on drug*. This is certainly a disruption in the family structure and has subsequently led to all sorts of

challenges for the young Black MSM in this study. This participant didn't even know his biological parents. At the age of 10 he experienced the loss of uncle's partner and at the age of 13 experienced the death of the uncle who was raising him. He refers to his uncle as "dad." He then moved in with this lesbian godmother and talks about being ashamed of having to talk about his family situation.

P8: *My biological father, I don't know him...I didn't know my mom... I saw her occasionally, but like twice. Well, just like my mother was addicted to drugs. I've never lived with her. That's why I grew up with my uncle [later referred to as his dad], and then having a bunch of half siblings. I grew up as an only child, but I did have siblings. I guess just having to explain that, you know, not typical story. I know I've been growing up with a gay couple. They're like a lesbian couple. Yeah, my uncle is gay. .. I was raised by my uncle who is a gay man. He passed when I was 13... Yeah, it's like my "dad" also he had two partners basically through my lifetime. The first one passed away when I was 10. So, I had two dads until I was 10. And then he got another partner for the last three. At least in my head I just kind of -- the way I accepted and explained it, like I also just kind of had a single parent. My "dad" was raising me. And yeah, I just kind of didn't talk about the rest. But then they kind of like made me feel like I was lying just because I didn't want to talk about it, like I was hiding something... And then my godmother was also gay, so she had partners. I lived with her when I was 13, so it's kind of like half my life was raised by two women and then -- I don't know. I find it interesting like now, but before I didn't. Before college I was like really ashamed of my upbringing or my story...It never felt abnormal to me I guess... It was actually socially when I started to feel that like something was wrong, like I had to explain myself or like knowing -- figuring out most stories of other people... I was okay with my family situation. I had two dads...I didn't talk about it. And I'm such a bad liar. So, I just don't talk about it and definitely very isolated. (HIV-positive)*

This participant's father was an alcoholic, used drugs and went to prison.

P6: *It's hard because the reason my mom and my dad separated was because my dad used drugs... He was an alcoholic and he liked to use drugs. He liked using cocaine. And not only that, he went to prison and stuff behind that. And those are very vivid in the early stages of my life. Those are very vivid images for me when I was young. (HIV-positive)*

This young man lived with many extended family members because this mother was on drugs.

P9: *I got raised by my great-great-families, my great-great aunt, great-great grandmamma... I left my family when I was five.... My Grandma told me my*

mom came to get me and I said, "No, I'm living with Auntie." And my mom said, "Come on." I said, "No, I'm living with Auntie," and she left me. My mom was on drugs anyway.... my dad was like blur. He wasn't like around like all that. He did his thing. He probably went off somewhere or do something else. (HIV-negative)

The young Black MSM also describe experiencing *adverse childhood experiences (ACE)*

including neglect, molestation, sexual abuse and physical abuse. This participant heard abuse in his home as a child, experienced sexual abuse by an uncle, and later verbal abuse by an older partner.

P8: *Like if I made mistakes kind of like saying like I'm a fuck up or when am I ever going to learn and I should listen to him because he's older, you know, and I'm not in school and I can't even finish that and blah, blah, blah. It was just like -- I don't know. It was just like negative sort of. All my mistakes or failures were just thrown in my face. I'm not the person to like talk bad, so I just kind of ...or ignored it and tried to look at the person sort of like their rage... Sexually, yes [there was abuse]. This wasn't a blood uncle. It was a family friend. This was when I was 12. Yeah, it was -- I don't know. I actually don't want to talk about it... And I was a latchkey kid. So, I would have the house to myself a lot as a child...I never saw it [abuse] physically, but I heard it...Yeah. And it was always just masked. (HIV-positive)*

This participant is describing experiences with neglect, being left in a crib with another child, so his aunt and grandmother went to court to obtain custody of him. His mother ended up in jail and he was cut off from this father.

P9: *I got taken away.,,No, I mean I never really got abused. I may have gotten left, I may have gotten being in a crib with another child. Like I'd be in a crib with another child. The child pee and I got some pee on me, because we're in this one crib. Parents put you in a crib with a play date and all you little babies -- you got hecka little babies in there all with diapers on. They pee on stuff. Things wet. All the babies wet because of that one baby. I never got like -- my Grands wasn't going for that....My Grandmama and my Auntie. They come get me a lot. They always come pick me up. So, it wasn't no taking. When I said I wanted to go, they went down the court and filed papers and get -- and she [his mother]gave up custody. My mom gave up custody to them. It wasn't like I went no where....It's just like she went to jail and all kind of stuff...Dad was just cut off. (HIV-negative)*

This participant was scared of this father, a pimp who was much older than his mother, that didn't like his playing with certain toys. The father later dies because of drugs. He then experiences his older cousin beating up his girlfriend as she tried to fight back.

P10: *My dad was a former pimp.... I really didn't really mess too much with my dad because he was a much older man. My dad was older than my mom. Let's put it that way. And when I was little he scared me. I was scared of my dad. He was like really loud. He didn't like the fact I played with -- I liked Barbies, My Little Ponies, Care Bear; all of them. And they lived in harmony with He-Man and the GI Joe and the Ninja Turtles. ..My dad didn't like that. He used to take my Little Ponies and the toys that I used to always like to play with. He'd just take them and get rid of them and all this stuff, just stuff like that. So, I really didn't care for the man....he was doing drugs and it got ahold and he died. It was kind of tragic for my family or whatever... I saw my cousin, my older cousin. He beat up his girlfriend and I was at the house there. And it kind of messed me up a little bit. Yeah. And I was real little and it kind of fucked me up and it made me like --like he was beating the shit up out of her.-- firing on her. She tried to fight back. Bow! Fired on her, threw her to the -- it was just a lot...Apparently that had been going on. I was just sad that I was there to see that and it just kind of fucked me up in the long run. I'm not like an abusive person, but seeing that kind of -- I don't know. It just kind of fucked me up for a long time. I used to have nightmares and shit. (HIV-negative)*

This participant's father was also addicted to drugs and alcohol, as well as being abusive to his mother.

P6: *It was depressing. My dad couldn't be around as much as he would have liked because my mom wouldn't allow him to be because she knew that he was addicted to drugs and alcohol and abusive...He wasn't abusive to me. He was more so abusive to my moms, maybe like beating on her or something like that...I heard it...I was young. (HIV-positive)*

And this participant shares about domestic abuse between his parents.

P11: *Yeah, I saw domestic abuse, domestic violence between my parents.... Well, just a mother's love and a father's love. I felt I was neglected in that department. (HIV-positive)*

Finally, the young Black MSM spoke about issues with *stigma, racism and homophobia*. All of these lead to various forms of *discrimination*. This participant describes going from dating girls to dating guys and the challenges he experienced. He ends up catching a bus to California.

- P5: *For me to do a 360 and all of a sudden just started exclusive like dating guys would have been real hard, real hard to explain, and to explain to all my friends and people that know me and grew up with me. And I didn't want to do that. I just didn't want to do that, you know? So, things weren't going well there. Yeah, things wasn't going well there. So, I got this idea that I was just going to catch a bus and just go to California. (homophobia) (HIV-positive)*

This young man had to come to terms with his sexual orientation. He also shares about experiences with racism and HIV stigma.

- P6: *I had to come to terms with the difference between feelings of shame and feelings of guilt. I had to realize that it wasn't nothing wrong with me for being gay, for liking dudes, and that I'm beautifully and wonderfully made. I had to really comprehend that before I could be all right with myself and then also present myself to the world and say this is who I am... I had somebody call me a nigger before. ..I've had people direct racial slurs, racial -- you're not good enough or you're black. I've had all of that, you know? ...I was going for this apartment one time. And as soon as dude found out that I had HIV, he didn't want me to live at that apartment anymore. That was one of the toughest. (homophobia, racism, stigma) (HIV-positive)*

This participant shares about being reluctant to "come out" in college. He knows his grandmother would not like that he was gay.

- P8: *I didn't come out to the college. So, still being socialized I think gay sex is wrong. And then so the drugs kind of take away that socialization...the self-acceptance of being gay takes awhile...my grandmother [INAUDIBLE] was like she accepted my uncle and my dad, which was her son. He was her favorite, but she didn't like that he was gay. (homophobia)*

This participant questions the need to "be out" and then having to deal with its ramifications.

- P9: *Why -- what's the big hooray about being out? It ain't no big hooray at being out. It's just -- You are -- being out, two things can happen. You could be happy or could be messed with. You could be teased. It's a bully thing. It's a bully thing. You don't want to be tarred and feathered. You could be out and someone -- you can be whatever you want to be, but you have to have a strong backbone. Don't be out and be no scary person, because you're going to get teased. You're going to get teased. People are going to say that. You are going to commit suicide, because you have a soft mind. You better have a strong heart, a strong body, sound and spirit to be out....The ridicule, it's just so much...People are ignorant.(homophobia, stigma) (HIV-negative)*

This young man experienced the distancing of people in his life when he “came out” and he feel the loss.

P10: *When I first came out some people distanced themselves from me because I was gay or whatever. I told them and they would stop coming around. A lot of friends just stopped coming around. A lot of friends just stopped calling. I don't even know what happened to their numbers. They just stopped calling. It's like they changed their numbers or some shit or something. And I mean friends I've known since childhood that's like -- they just stopped fucking with me or whatever. And it kind of hurt a little bit.... Like on the inside, like I won't show it on the outside. I'll just be the same regular me, but on the inside that shit do hurt sometimes. But that's how I am and if they stop fucking with me because I'm gay or whatever that's on them, you know? I can't really change them, but I wish some of them would have stayed around. But what can I do? (homophobia) (HIV-negative)*

Finally, this narrative highlights the homophobia this participant experienced from his brothers.

He has also had friends struggle with gay bashing and other violent crimes.

P11: *Well, three of my brothers don't talk to me because I'm gay. They don't like gay people. I would say more about it if I knew more. If I could talk to them and ask them why they didn't and they would answer then I would, but I can't. They just don't like gay people...That makes me a little bit cold towards them.... Well, I've never been gay bashed. So, I wouldn't know. But I have friends who have victimized or victims of, you know, gay hate crimes or whatever you want to call them. I just say that because that's the terminology that we would use for that. I've had friends that aren't so lucky, that haven't had the luxury, or -- I say luxury, but I say haven't had the opportunity to hide their sexuality. They can't really hide it because it's them. So, they've been victim of violent crimes from society; being jumped and having people beat them up or throw things at them. I've never really experienced that, so I wouldn't know what that's like. But watching my friends, I could only imagine that it would probably be a little bit hard to deal with. And I've even had some friends commit suicide because of it...I think it had to do with not having somebody to talk to about their problems and not having somebody to go to when they have questions, somebody to answer them. You know, just not have the support that they felt they needed and not wanting to be here anymore. (homophobia) (HIV-positive)*

Conclusion

The three aims of this study were to: (1) understand the role substance use plays in the lives of young Black MSM, (2) describe the perceived risks for acquiring HIV among young

Black MSM, and (3) explore the historical and social contextual experiences that have influenced young Black MSM. The excerpts from the narratives reveal some of the factors contributing to substance use and HIV among young Black MSM. It is clear that the issues are complex and multifaceted. The themes identified in this study highlight the sentiments of young Black MSM in the Bay Area as it relates to this topic. From the narratives, it is clear that drug and alcohol use starts at an early age and continues throughout the lives of these young men, for a number of different reasons, often times leading them to engage in HIV sexual risk behaviors.

This author also wonders how substance use, particularly methamphetamine, contributes to the sexual risk-taking among this group of men, since most of them were testing regularly for HIV in the past. It seems that once they are under the influence, they no longer care about using a condom for protection or are not able or willing to negotiate safer sexual practices with their partners. There does not seem to be a heightened concern about avoiding becoming infected with HIV, but instead almost a sense of complacency and expectancy in terms of acquiring the disease; herein referred to as HIV risk reduction apathy.

Finally, the third aim was added to the study in hopes of providing some additional insight into the lives of young Black MSM. There are definitely a significant number of these participants who have come from broken families, with their parents or primary caregivers using drugs or alcohol, sometimes with the child having to be removed from the home. The narratives also highlight issues with neglect, molestation, sexual abuse, and physical abuse. All of the young men spoke about experiencing these. Again, this author must wonder how all of these things adversely contribute to the lives of these young Black MSM and what then is needed and wanted in the community to have an impact and change the outcomes of some of these behaviors.

Chapter 5: Discussion

Meaning of findings in relation to research aims

The aims of this research study were to better understand the role substance use plays in the lives of young Black MSM, describe their perceived risks for acquiring HIV, and explore the historical and social contextual experiences that have influenced them. The four major findings in this study include, (1) there was a lot going on in the homes of these participants. Almost all of the young Black MSM discussed early substance use exposure in their family, including parents who were also drugs. The young men shared about broken family structures, including abuse and neglect, (2) thirty years into the AIDS epidemic, stigma and homophobia continue to be an issue for young Black MSM. Most of the participants were either kicked out of their family homes, asked to leave by their family, or wanted to get away from their family so that they could be themselves, (3) with the prevalence and exposure to methamphetamine in the San Francisco, young Black MSM discover the benefits of this drug for numbing, masking, and coping with everything from being gay, gay sex, dealing with peer pressure, and for sexual enhancement and survival sex, and (4) once under the influence of methamphetamine, the participants don't care about condoms, nor do they have the ability to negotiate condom usage with their partners. There is a sense of anticipation, resignation and acceptance about acquiring HIV; HIV risk reduction apathy.

Aim 1: Understanding the role that substance use plays in the lives of young Black MSM

Surprisingly, the results of this study do not draw the same conclusions as previously cited studies about substance use with young Black MSM in other cities. Namely, these studies discuss the prevalence of alcohol, marijuana, crack cocaine, and methamphetamine as the primary drugs of choice for this population (Harawa et al., 2008; Purcell, Parsons, Halkitis, Mizuno & Woods, 2001). In this study, methamphetamine is the primary drug of choice. It

appears that the high exposure, prevalence, and access to methamphetamine in San Francisco among the predominantly White MSM population has had an impact in the lives of the young Black MSM in this study. Harawa (2008) discussed how methamphetamine plays a role in unprotected sex and this study supports those findings.

This researcher also wonders about the impact that early exposure and initiation of drugs or alcohol in their childhood homes has contributed to later substance use. The median age for initiation of drug and sex for the participants in this study was 15 years old and the mean age of the participants is 26 years old. On average, that would indicate approximately 10 years of substance use experience for the participants in this study. Many of the participants spoke about doing drugs or alcohol, either on their own or with family members at a very young age. This seems to start the substance using behavior, then once they leave home or gets kicked out because of issues with their sexual orientation, the subsequent rejection, judgment, and lack of acceptance further fuels their desire to engage in substance use as part of the new community they find themselves involved. Namely, peer pressure from other MSM that they encounter, usually older White MSM who have access to drugs and the housing needed by the homeless young Black MSM in this study. In studies by both Warren et al. (2007) and VanDevanter et al.(2011), it was noted that with young Black MSM, unprotected receptive anal intercourse was associated with being kicked out of the home because of sexual orientation and younger age at initiation of sexual behavior. These social and environment issues must be addressed, as well as the accompanying discrimination.

The young Black MSM in this study describe dealing with feelings of abandonment, being alone, lonely, and the need to fit into their new community and have a sense of belonging. This is coupled with their fear of being additionally rejected by their new community and

underlying issues with love and trust. As part of their need to belong, these young Black men use drugs for emotional numbing so that they can deal with their new life circumstances. In addition, the young men now have to deal with survival, needing money for meet their needs including food, clothing and shelter so they can have a place to sleep and shower. As a way to support their substance use and meet their basic needs, they begin to engage in transactional sex (Harawa, 2008), only to discover the sexual enhancement benefit of methamphetamine. This drug allows them to have many different sexual encounters, over and over again. Other studies have identified the connection between simulant use and how that leads to unprotected anal sex with casual male partners, particularly with young Black MSM (Harawa, 2004; Harawa, 2008; Mimiaga, 2010).

Also, the young Black MSM in this study say there is a power in youth sex, since older MSM want to have sex with younger MSM. The study participants then find themselves under the dominant influences of the older MSM who are their “tricks and johns” who start to place sexual demands on them, promising more drugs or more money if they engage in high risk behaviors such as unprotected receptive anal intercourse. Fields (2011) noted that the masculine (dominant) partner, usually the top guy, is generally the one who makes the decisions about condom use. Once MSM use substances, it enhances their sexuality and escapes self-awareness about HIV risk (McKirnan et al., 2001). This is definitely an area of concern for this researcher. For a follow-up to this study or in future studies, it would be important for the researcher to consistently inquire about and document the race of the older MSM who are the “tricks and johns” since this was not consistently done throughout all the interviews. In this study, the information was only gathered by some of the clients if the theme was brought up in the interview, instead of as an intentional and direct question on the Interview Questions

(APPENDIX G). Some participants identified that the “tricks or johns” were usually older White MSM who were in a position to have access to housing, afford drugs, and to offer these young Black men money to engage in sex with them. This power dynamics and unequal treatment in sexual relationships, as described earlier in this paper by Godfrey-Smith (2003), Im (2010) and Jansen (2004), is a reflection of feminist perspective and how this impacts young Black MSM.

Finally, it is already known that there exist a strong correlation between substance use and the gay community and this certainly is the case among this group of young Black MSM. It would seem that substance use, particularly methamphetamine, has many benefits for young Black MSM. Substance use also helps them cope with gay sex and being gay, often times as a part of engaging with other members of the larger White gay community, who already have stable housing, financial resources, and access to drugs.

There must be a way to break this cycle and empower young Black MSM. Something must be done so that young Black men will not continue to experience an increasing rate of new HIV infections at a disproportionate rate (Denning, 1997). Perhaps it starts at a young age by minimizing or eliminating the early exposure and initiation of drugs or alcohol in their family, or maybe by having services and safe spaces for them to open up and feel loved and accepted just the way they are despite their sexual orientation. Garcia et al. (2015), offers the following as a working definition of “safe spaces”: (1) safe spaces promote supportive social norms and peer networks through a range of leisurely activities that are culturally relevant, (2) safe spaces enable human development by providing skill-building opportunities to those who experience marginalization from educational and work environments, and (3) safe spaces promote empowerment and community mobilization against stigma, discrimination and violence. These safe spaces must be racially and ethnically appropriate since it is already known that Blacks do

not respond or attend interventions targeting mainstream White MSM and often experience racism in gay social settings (Wong et al., 2010). This is, in a sense, exposure to double racism: rejection for being Black and rejection for being gay.

Many of the participants suggested the need for websites and other messaging warning young MSM about the challenges of leaving home, having to survive on the street, and being taken advantage of by older MSM. It is also imperative to develop educational programs with targeted prevention message strategies specifically tailored to the young Black MSM community that address the substance use and HIV risk behaviors.

Aim 2: Describe the perceived risks for acquiring HIV among young Black MSM.

From the narratives, almost all of the participants were aware of HIV and testing regularly. For those who eventually tested positive for HIV, they describe their diagnosis as a sense of relief and something they are not surprised about because of the behavior they were engaging in at the time, namely unprotected anal intercourse because of being under the influence of drugs or alcohol. This highlights the need to have HIV prevention programs that focus on decreasing substance use, specifically before sex (Purcell, 2001). There was almost a sense of acceptance and resignation about eventually becoming HIV-positive; HIV risk reduction apathy. For the participants in this study, becoming HIV-positive is life-changing and considered a blessing to them because of their self-described destructive path caused by substance use. The HIV diagnosis becomes their moment of the realization of the need for change, empowerment, and the need to take control of their lives by changing their behavior, including stopping or reducing their drug use. More importantly, they also describe the social benefits of being HIV-positive including housing, financial assistance, access to food through government assistance programs, and social services support that they were not previously able to access when they were HIV-negative. In a way, these things almost become incentive to engage in substance use

and HIV risk behaviors. Something is seriously wrong with this kind of thinking, but also speaks to the need of providing more resources and services to at-risk young Black MSM.

Thirty years later, the AIDS epidemic continues to disproportionately impact the lives of young Black MSM in the United States. This researcher believes that we have not yet fully seen the full devastation of this disease among this population, particularly since we already know that they tend to test late in the disease process, have higher morbidity, and subsequently have higher mortality rates. According to the CDC (2016), MSM, particularly young Black MSM, are most seriously affected by HIV. Blacks face the most severe burden of HIV. Furthermore, in 2010, the greatest number of new HIV infections (4,800) among MSM occurred in young Black MSM aged 13–24. Young Black MSM accounted for 45% of new HIV infections among Black MSM and 55% of new HIV infections among young MSM overall (CDC, 2016). Clearly, the epidemic is not over, particularly for this young population.

There does not seem to be a historical context and significance among young Black MSM about the death and devastation caused by HIV/AIDS in the earlier years. Today, young Black MSM view HIV and AIDS as something that they just have to take pill for and they can be okay. The participants in this study certainly do not lack awareness about HIV. It was surprising to see that many of the participants were testing regularly for HIV, especially since there is little outreach and effort being targeted to this age group and demographic. Even with varying degrees of knowledge about HIV, most of the participants were aware that they were engaging in risky behaviors, particularly when they were under the influence of drugs or alcohol. As other researchers have noted (Harawa et al., 2004; Harawa et al., 2008; VanDevanter et al., 2011), it is fairly common that once young Black MSM are under the influence of drugs or alcohol, they lose their interest and ability to negotiate condom usage or to avoid engaging in unprotected

receptive anal intercourse (Harawa, 2004). Unprotected receptive anal intercourse, also called bottoming, is generally relegated to less dominant gay men. In 2003, Frasca noted that this position for MSM is similar to women, who are not always able to direct or refuse to engage in sexual activity with their partner and also not able to make decisions about whether or not a condom will be used. Again, the latter of these has to do with the power dynamics of the relationships, particularly with older MSM, since the young Black MSM are in a powerless position - homeless, without food, clothing or shelter- that makes them receptive to doing whatever is necessary to get these needs met. This researcher wonders about the age and racial power influences that happen when young Black MSM are with older White MSM. Perhaps this is another example of the power dynamics in sexual relationships discussed by Godfrey-Smith (2003), Im (2010) and Jansen (2004). Radical feminism would reject such domination and inequality. The solution to this would be to offer young Black MSM the educational tools and resources needed for them to begin navigating condom negotiation and usage successfully.

What is it about substance use that overpowers the desire to take care of own well-being? Perhaps we are failing miserably in our teachings and conversations about drug education and sex education. Maybe we have not done enough work to educate this younger generation about the consequences of substance use and the associated HIV sexual risk behaviors. In light of the upbringing of these young men, this researcher wonders where these guys would even begin to get information about being an MSM and related sexual health. It is imperative that educational materials also be racially and ethnically appropriate for this age group, accessible in locations that would be safe for them. The HIV epidemic certainly is not over and young Black MSM will continue to be disproportionately impacted unless something drastic is done. This researcher believes that we have not yet seen the full devastation of this disease in the Black community.

Utilizing harm reduction for HIV sexual risks behaviors and substance use

Harm reduction would be the perfect educational framework to use for both reducing harm caused by both HIV sexual risk behaviors and substance use since it works well for young people (Erickson, 1995). Of course, utilizing this model would require meeting young Black MSM where they are at in terms of their readiness for any kind of change. Harm reduction entails the idea of acceptance of the behavior brought on by substance use, including HIV sexual risk behavior, while at the same time making small attempts to minimize, not eliminate, the harmful consequences rather than trying to eliminate such use altogether (Erickson, 1995, Erickson, 1999; Hilton, Thompson, Moore-Dempsey & Janzen, 2000). Harm reduction works well if a substance user is not yet interested, unwilling, or unable to abstain completely (Weiker, Edgington & Kipke, 1999). Providing a choice of goals may increase a young Black MSM's motivation to change substance use behavior and ease into a controlled, moderated, or abstinent lifestyle (Marlatt & Witkiewitz, 2002). When individuals are given a choice of goals, many people choose abstinence (46%) and over the course of treatment there is more movement in the direction of moderation to abstinence goals (Marlatt & Witkiewitz, 2002). Other goals might include, but not limited to: (1) modification of overall substance use, (2) consideration of ways to increase condom accessibility (having it readily available) and usage, and (4) practicing condom negotiation skills (role-play). Another part of harm reduction would be to have substance abuse prevention education, treatment, and medical services available that specifically address the needs of this vulnerable population (Mimiaga et al., 2009; Sutton, 2011; VanDevanter et al., 2011), remembering that young Black MSM need interventions directly targeted towards them (Wong et al., 2008).

Stigma, Homophobia and the Black community

Stigma is defined as an attitude of disapproval and discontent towards an individual or group from other individuals or community and public institutions because of the presence of an attribute perceived as undesirable; a mark of disgrace associated with a particular circumstance, quality, or person (such as homosexuality or HIV). Homophobia encompasses a range of negative attitudes and feelings toward homosexuality or people who are identified or perceived as being lesbian, gay, bisexual or transgender (LGBT); irrational fear of, aversion to, or discrimination against homosexuality or homosexuals (Merriam-Webster, 2016). It has been defined as contempt, prejudice, aversion, hatred or antipathy, may be based on irrational fear, and is sometimes related to religious beliefs. In the Black community, both stigma and homophobia continue to be a problem for the young Black MSM in this study. Being homosexual has led to participants being kicked out of their family homes, asked to leave by their family, or wanting to get away from their family so that they could be themselves. Most have ended up in San Francisco as a safe place, only to face homelessness and having to figure out how to survive on their own. These insecurity issues must be addressed. In fact, a growing body of evidence indicates that simply growing up in discriminatory environments is associated with increased psychological distress and fewer attempts to negotiate safe sex (Quinn & Dickson-Gomez, 2016).

Stigma associated with both homosexuality and HIV will continue to make Black MSM practices stay hidden (Miller, 2015) and continue to fuel the epidemic among this population. More effort needs to focus on minimizing stigma around HIV and normalizing HIV testing for all people as suggested by the National HIV/AIDS Health Strategy [NHAS] (2015). Stigma can factor into individual interactions and affect larger societal and institutional forces (NHAS,

2015). Discrimination can be a consequence of stigma and may occur when unfair actions are made against individuals on the basis of their belonging to a particular stigmatized group.

Quinn & Dickson-Gomez (2016) explored homonegativity, religiosity, and the intersecting identities of young Black MSM. Homonegativity, or the stigma associated with homosexuality, may be an important social factor influencing racial disparities in HIV. They conducted 30 semi-structured interviews with young Black MSM ages 16–24. Homonegativity may make it difficult for some young Black MSM to be open about their same-sex relationships, increasing stress and limiting social support, and subsequently increasing risk for HIV via increased sexual and drug-related risk behaviors. The Black Church has been identified as a central feature of the Black community and often dictates or influences community norms and values. The Church is an integral aspect of young Black MSM's identity, history, family, and community life. As such, the Church's construction of homosexuality dominated throughout their lives. The expectations of masculinity facing young Black MSM emphasize expectations of physical and sexual dominance, which are viewed as incompatible with homosexuality. Participants describe complex decision-making around whether to disclose their sexuality and to whom, and weigh the consequences of disclosure and non-disclosure. For many young Black MSM, their multiple, intersecting identities significantly influenced their experiences with homonegativity and their decisions about disclosing their sexual orientation. Findings lend support for the need to develop community-, family-, and church-based stigma reduction interventions that address homonegativity among this population.

In another study by Arnold, Rebchook & Kegeles (2014), they found that HIV-related stigma and homophobia, within the larger societal context of racism, were related to sexual risk behavior, reluctance to obtain HIV testing or care, lower adherence to treatment medication, and

disclosure of a positive HIV status to sexual partners. Participants experienced homophobia and HIV-related stigma from churches and families within the Black community, and from friends within the Black gay community, that otherwise provide support in the face of racism. They suggest that programs that work at the community level to mobilize various sub-communities to confront the stigmatization of homosexuality and HIV within Black communities, and racism in mainstream society, have tremendous potential to bring about a change in the social processes that generate stigma and the vulnerability to HIV that it creates. Programs must also aim to bolster psychological mechanisms at the individual level to help young men cope with stigmatization of their identities, and instill young Black MSM with a sense of pride to offset some of the social rejection that they experience. In addition to this, programs must seek out ways to create a sense of community among young Black MSM, regardless of status, in order to provide support for having safer sex, for getting tested, for getting into treatment, and for dealing with the multiple sources of stigma they encounter

Substance use has also been associated with stigma, discrimination and harassment (Wong et al., 2010). HIV-related stigma can be confounded with or made more complicated by stigma related to substance use, mental health, sexual orientation, gender identity, race/ethnicity, or sex work. Stigma can lead to many negative consequences for people living with HIV. It is imperative that all levels of government recognize these various biases exist and work to combat stigma and discrimination in order to reduce new infections and improve health outcomes for people living with HIV. According to the NHAS (2015), stigma and discrimination must be eliminated in order to diminish barriers to HIV prevention, testing, and care. We must find effective strategies for managing stigma, thereby decreasing homophobia.

The goals of San Francisco's "Getting to Zero" consortium (2015), consisting of the local government, health department, planning councils, universities, community-based organizations, and care providers, large and small are "Zero HIV infections, zero HIV deaths, zero HIV stigma." Stigma may take the form of overt discrimination, leading to violence against those living with or at risk of HIV, preventing individuals from accessing services, and resulting in psychological and physical trauma. Eliminating this manifestation of stigma requires a focus on those who discriminate (or are at risk of discriminating), seeking to intervene on behaviors that knowingly and unknowingly harm people and communities affected by HIV. Creating safe spaces where all individuals feel accepted and respected will enable more individuals to get tested for HIV, enter and stay in care when diagnosed, adhere to medication regimens, and adopt prevention measures, including disclosing their HIV status.

Stigma, related homophobia and/or HIV status, are a part of the challenges facing young Black MSM and have been discussed above. Homophobia is further defined as a dislike of or prejudice against homosexual people (Merriam-Webster, 2016). Homophobia results in greater stigmatization of homosexuality in Black communities and, in turn, causes more "closeted", hidden behaviors (Miller, 2005) and produces more stress among Black MSM (Lemelle & Battle, 2004). Understanding with the intent of abolishing homophobia is not only a psychological issue but, arguably, a public health one as well. With the increasing prevalence and incidence of HIV/AIDS in Black communities, negative attitudes toward gay men are thought to have other than stress health-related effects. There is a reported relationship between shame and internalized negative attitudes toward gay men that result in avoidance of social support and utilization of public health (Lemelle & Battle, 2004).

While young Black MSM often face homophobic bigotry from heterosexual Black Americans, they also have come into conflict with LGBT White Americans due to matters of race and color in United States LGBT culture (Lemelle & Battle, 2004; Wong et al., 2004). Homophobia is considered to be quite prevalent within the Black community. Numerous reasons are given for this, including: the image young Black males are supposed to convey in the public sphere; the fact that homosexuality is often seen as antithetical to being Black in the African American community; and the association of the Black community with the church in the United States. In 2008, President Obama has acknowledged homophobia within the Black community, and in his speech made a statement to the community at Ebenezer Baptist Church in Atlanta, saying that: "If we are honest with ourselves, we'll acknowledge that our own community has not always been true to [Martin Luther] King's vision of a beloved community... We have scorned our gay brothers and sisters instead of embracing them"

Recommendations from the NHAS

The NHAS (2015) makes the following recommendations about ways to fight the HIV epidemic, particularly in the Black community: (1) *educating young people about HIV before they begin engaging in behaviors that place them at risk for HIV infection should be a priority.* Appropriately, it is a parent's job to instill values and to provide the moral and ethical foundation for their children, but schools have an important role in providing access to current and accurate information about the biological and scientific aspects of health education. It is important to provide access to a baseline of health education information that is grounded in the benefits of abstinence and delaying or limiting sexual activity, while ensuring that youth who make the decision to be sexually active have the information they need to take steps to protect themselves, (2) *promote age-appropriate HIV and STI prevention education for all Americans:* Too many

Americans do not have the basic facts about HIV and other sexually transmitted infections. Sustained and reinforcing education is needed to effectively encourage people across the age span, particularly young Black MSM, to take steps to reduce their risk for infection, and (3) *utilize evidence-based social marketing and education campaigns*. Outreach and engagement through traditional media (radio, television, and print) and networked media (such as online health sites, search providers, social media, and mobile applications) must be increased to educate and engage the public about how HIV is transmitted and to reduce misperceptions about HIV transmission. Efforts will be made to utilize and build upon World AIDS Day (December 1st) and National HIV Testing Day (June 27th), National Black HIV/AIDS Awareness Day (February 7th), as well as other key dates and ongoing activities throughout the year.

The overall goal of the NHAS (2015) is to prevent HIV among Black Americans, especially young Black MSM. To lower risks for all Americans, prevention efforts should acknowledge the heavy burden of HIV among Black Americans and target resources appropriately. Promote a more holistic approach to health that addresses not only HIV prevention among African Americans, gay and bisexual men, and substance users, but also the prevention of HIV related co-morbidities, such as STDs and hepatitis B and C. The hope is that one day the United States will become a place where new HIV infections are rare, and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination. This researcher dreams of that day too and hopes to see it happen in his lifetime but there is still much work that needs to be done, particularly with young Black MSM.

Aim 3: Explore the historical and social contextual experiences that have influenced young Black MSM.

The narratives in this study highlighted many of the additional historical and social contextual experiences that have influenced the lives of young Black MSM. It is also clear that there are a number of other difficult issues in the family settings of the young Black MSM in this study, including parental drug and alcohol use, displacement of participants into the homes of other relatives, and in at least one case, involvement with Child Protective Services. These are further complicated with issues of neglect, molestation, sexual abuse, and physical abuse, which are all considered adverse childhood experience (ACE) and associated with substance use (Wong et al. 2010).

According to Brown, Masho, Perera, Mezuk & Cohen (2015), ACEs are a particular set of negative childhood exposures, for example, emotional, physical, or sexual abuse, witnessing violence among household members, losing a parent due to death or divorce, or household mental illness, substance abuse or criminal behavior. ACEs pose a major public health challenge in the United States and recent estimates show that six in ten people in the general population have been exposed to at least one adverse childhood event, and 8.7% have reported five or more ACEs. ACEs have been linked to suicide attempts, using illicit drugs, smoking, and having multiple sex partners.

Brown et al. (2015) adds, research using a United States population-based sample showed that sexual minorities, such as MSM, had higher rates of ACEs and higher odds of experiencing multiple ACEs compared to heterosexuals. ACEs have been shown to be associated with sexual debut in early adolescence compared to later adolescence or as an adult. Sexual abuse and physical abuse during childhood have also been linked to early sexual debut. The sexual risk behaviors of individuals who have been exposed to ACEs, such as early sexual debut, may

represent attempts to obtain close interpersonal connections. Among MSM, sexual debut before age 16 was associated with exchanging sex for drugs or money, marijuana use, emotional and psychological problems associated with substance use, and suicide attempts. Some of these have been discussed by the participants in this study. It was also noted that MSM had higher odds of exposure to child abuse (physical or sexual) and housing adversity (homelessness or being forced out of their homes by parents/caregivers) compared to heterosexuals. This has also been described by the participants in their narratives in this study.

Schneeberger, Dietl, Muenzenmaier, Huber, & Lang (2014) identified a similar problem called stressful childhood experiences (SCE) that are associated with many different health outcomes, such as psychiatric symptoms, physical illnesses, alcohol and drug abuse, and victimization experiences. Lesbian, gay, bisexual, and transgender (LGBT) people are at risk to be victims of SCE and show higher prevalence of SCE when compared with heterosexual controls. In a systematic review, studies reported childhood sexual abuse, childhood physical abuse, childhood emotional abuse, childhood physical neglect, and childhood emotional neglect. Items of household dysfunction were substance abuse of caregiver, parental separation, family history of mental illness, incarceration of caregiver, and witnessing violence. The young Black MSM in this study have certainly given examples of many of these experiences in their narratives.

Moreover, Schneeberger et al. (2015) notes, problems with alcohol and illicit drug use, as well as promiscuity and history of sexually transmitted diseases, were shown to be related to SCE. Outcomes related to SCE in LGBT populations included psychiatric symptoms, substance abuse, revictimization, dysfunctional behavioral adjustments, and disorders to physical ailments. In sum, LGBT populations are often subject to SCE and suffer throughout adulthood from many

negative health outcomes. Health care providers should be attentive to the possibility of SCE in their LGBT clients, and the potential long-term negative impacts on both physical and mental health, making trauma informed care a necessity in the health care delivery system of this population.

Significance

Young Black MSM between the ages of 13 and 29 years have the highest rates of HIV infection in the United States and substance use is a contributing factor. This study is one of the few qualitative studies to explore the experiences of substance use and HIV sexual risk behaviors among young Black MSM and fills a gap in the current scientific literature. It is clear from the narratives from the participants in this study that there are multiple influences that have contributed to their substance use and HIV sexual risk behaviors. With this information, it is easier to understand the multitude of issues that need to be considered when working with this population. If we are to have an impact in reducing substance use and HIV among this population, then we must have our efforts be guided by the young Black MSM that we want to reach. We are not going to reach them using the same interventions that have been used with the mainstream White MSM community. Efforts must be racially and ethnically appropriate for young Black MSM, with messages that reflect their unique circumstances. Their voices and experiences must be heard and taken into consideration when developing programs to address their specific needs.

Benefits of this Study

On a couple of occasions, participants shared about the benefit of doing the interview and sharing their story with the researcher. Here are a couple of those narratives that highlight be

benefits of this study for the participants. The first participant shared about how the interview allowed him to reflect back over his life and get a better perspective of this progress.

P8: *I mean thank you because it allowed me to realize the progression I've made in the last six years because I always kind of looked back as like, "Oh, like these six to seven years has been really hard and I've had to do a lot of self-seeking and finding myself." It's not all negative. I need those experiences to like figure out what I believe from being okay with myself. And then seeing the progression from childhood and now, having to like gain my own perspective or just being okay with my story.*

This participant felt that by sharing his story, a weight had been lifted off of him and that there was a benefit with sharing about something as personal as substance use and HIV risk behaviors.

P12: *I think you did a great job with your questions actually...I feel like a weight has been lifted...Yes. Because speaking of things is healing as well and it keeps you from also wanting to use and also corrective behavior. So, getting comfortable with opening my mouth, saying stuff that technically is taboo, it helps.*

Limitations of this Study

The limitations of this study include the small purposive, convenience sample size and the limited age range of the study participants. It was challenging to recruit participants for this study. Although a definite set of experiences emerged in the analysis and there was data saturation of the narrative themes, it would have been helpful to have more participants and perhaps obtained more depth in the range of experiences. In addition, this study was done with only young Black MSM in the Bay Area and cannot be transferred to other racial populations or similar participants in other geographic areas. Another limitation is that these participants were all recruited for community-based organizations and not reflective of the homeless or street community previously discussed to provide a richer, broader range of experiences regarding substance use and HIV sexual risk behaviors among young Black MSM.

Future Research

More research needs to be done that specifically focuses on young Black MSM exclusively. Substance use among this population, particularly before and during sex (Purcell,2001) and associated HIV risk behaviors is underexplored. HIV among young Black MSM will continue to be a major public health concern. Future studies should consider recruiting young Black MSM who are not directly coming from community-based organizations, but perhaps recruited from other locations and venues, to provide additional perspectives about this topic. These venues might include streets, homeless shelters, bars, bath houses, adult sex stores, and similar places where these young men are known to congregate. It would also be invaluable to hear from young Black MSM in other parts of the United States, particularly in the South Louisiana, Tennessee, and Virginia as well as other cities that have a larger Black community such as Atlanta or Washington DC. Finally, it would be beneficial to develop a racially and ethnically appropriate substance use or HIV prevention program, incorporating a biomedical component such as urine testing or HIV screening, to measure and evaluate behavior change over a period of time.

Implications for Nursing

Nurses and community service providers having interactions with young Black MSM should be aware of the HIV epidemic among this population, as well as potential issues with substance use. The following key considerations are recommended:

- Provide information, education and resources regarding HIV testing, counseling, and treatment, as needed, that is racially and ethnically appropriate for this population.

- Understand the impact that perceived discrimination, racism and homophobia can have on health care, and practice culturally humility to facilitate improved working relationships and health outcomes.
- Perform a thorough comprehensive health assessment, carefully evaluating HIV sexual risk behaviors, substance use behavior, and also and evaluation of ACE and other social influences that might have an impact on the individual's health.

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Appendix A: Recruitment Flyer**UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
RESEARCH STUDY****ARE YOU.....**

- **A YOUNG BLACK MAN**
- **BETWEEN THE AGES OF 13 – 29**

HAVE YOU....

- **HAVE HAD SEX WITH ANOTHER MAN**
- **HAVE USED DRUGS AND/OR ALCOHOL**

*****YOU HAVE THE OPPORTUNITY TO SHARE YOUR UNIQUE STORY*****

Dr. Carol Dawson-Rose and Austin Nation, RN, PhD (c) from UCSF School of Nursing are doing a study to better understand substance use, sexual risk behavior and HIV risk for young Black men. Having a better understanding of the role that substance use has in HIV risk will help health care providers develop better programs to protect such young men.

Interviews will last no longer than 2 hours at a date, time and mutually agreeable location. The location has be to safe, private and secure for both participant and interviewer. A second interview, also no longer than 2 hours, may be necessary.

VOLUNTEERS WILL RECEIVE \$20 GIFT CARD FOR EACH INTERVIEW

The study is completely voluntary and you can stop participating at any time. You can also leave the study at any time. **ALL OF YOUR PERSONAL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL**

If you are interested in sharing your story, please contact Austin Nation at [REDACTED] [REDACTED] or [REDACTED] to discuss any questions about the study or to schedule an interview.

Appendix B: Recruitment Information Sheet

**UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
RECRUITMENT INFORMATION SHEET**

The purpose of this study is to better understand substance use and HIV risk for young men. Having a better understanding of the role that substance use has in HIV risk will help health care providers develop better programs to protect such young men. The study researchers, Dr. Carol Dawson-Rose, RN, PhD and Austin Nation, RN, MSN from the UCSF School of Nursing, Department of Social and Behavioral Sciences will explain this study to you.

Research studies include only people who choose to take part. Please take your time to make your decision about participating, and you can discuss your decision with your family or friends if you wish. If you have any questions you may ask the researchers.

What will happen if I take part in this study?

If you agree, the following procedures will occur:

- Prior to enrollment in the study all potential participants must undergo an initial telephone screening to determine eligibility and to ensure that involvement in the study will not expose them to untoward stress.
- You will meet with the researcher for a private interview at a date, time and mutually agreeable location that is safe, private, and secure for both you and the interviewer. You will be asked to describe your experiences with substance use as a HIV-positive young man who has sex with men. This interview will take no longer than 2 hours. A second interview may be necessary. Your contact information will be kept secure and destroyed after the second interview or 12 weeks.
- Participating in this study is voluntary and participants may leave the study at any time.

Will I be paid for taking part in this study?

In return for your time, effort and travel expenses you will be paid \$20.00 per interview for taking part in this study, the maximum payment amount will be \$40.00. You will be paid in cash, immediately following the completion of each interview.

Any interested men should contact me directly with any questions, concerns, or to be screened:

Austin Nation: [redacted] (cell) or email at: [redacted]

[redacted]	Young, Black Men's Study Austin Nation
[redacted]	Young, Black Men's Study Austin Nation
[redacted]	Young, Black Men's Study Austin Nation
[redacted]	Young, Black Men's Study Austin Nation
[redacted]	Young, Black Men's Study Austin Nation
7	Young, Black Men's Study Austin Nation

Appendix C: Telephone Screening Tool

Hello, this is Austin Nation, the PhD candidate from UCSF. Thank you for contacting me. I am pleased that you are interested in our study. I am working with Dr. Carol Dawson-Rose to better understand young Black men, substance use, and HIV risk. Taking part in the study is voluntary and once you agree to take part, you may still leave the study at any time. Any questions so far?

If you decide to participate, you will be asked choose a date and time to take part in one or two private one-on-one interviews at a mutually agreeable location that is safe, private, and secure for both participant and interviewer to talk about your experiences and to share your story.

All your information will be kept strictly confidential. The interview will take no longer than 2 hours. A second interview may be necessary to clarify information from the first interview and will also take no longer than 2 hours. In return for your time, effort, and travel expenses, you will be paid \$20.00 per interview for taking part in this study; the maximum payment amount will be \$40.00. You will be paid with a gift card immediately following the completion of each interview. Your contact information will be kept secure and destroyed after the second interview.

Any questions for me at this point?

Okay, let's find out if you are eligible for the study. Please answer the following questions:

- (1) From what agency or from where did you hear about this study?
- (2) How old are you? Only eligible if between the ages of 13-35
- (3) Are you HIV-positive, HIV-negative or Don't Know?
- (4) Have you had sex with men, women or both? Only eligible if have had sex with men or both
- (5) Do you drink or get high prior to having sex?
- (6) When was the last time you drank to intoxication or gotten high? To rule out inability to provide informed consent, as evidenced by cognitive impairment, active psychosis, acute intoxication, or significant confusion.

If potential participant meets all the eligibility inclusion criteria:

Well, based on your answers, it appears that you are eligible to take part in the study. If you are still interested in being involved, do you have any questions that I can answer for you before we set-up a date, time, and mutually agreeable location that is safe, private and secure for both participant and interviewer. Again, at the beginning of our interview, I will describe the study more in detail and go over a form for you to sign stating that you understand and freely agree to

participate in the study. I will also need you to fill out information about yourself. I need to know if you are okay with that?

Okay, let's come up with a date, time and place to meet. What and where would work best for you? You already have my contact information [REDACTED] or [REDACTED]. Let me know if anything changes for you between now and the time we are supposed to meet or if you later think of any questions you want to ask me. Thank you again and I look forward to meeting you. Any questions before we hang up?

If potential participant does not meet the eligibility inclusion criteria:

Based on your answers, it appears that you are NOT eligible to take part in the study. I want to thank you for your interest. If you know of others who you think will qualify, please feel free to pass the study information or my contact information on to them.

Again, thank you for your willingness to participate and keep an eye out for other studies.

Good-bye.

Appendix D: Information Sheet**UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
INFORMATION SHEET TO PARTICIPATE IN A RESEARCH STUDY**

Study Title: Perceptions from HIV-positive and HIV-negative young men who have sex with men (MSM) about the role substance use plays in their lived experiences.

The purpose of this study is to better understand the meaning of substance use for HIV-positive and HIV-negative young men who have sex with men. Having a better understanding of the role that substance use has in the risk of becoming HIV-positive will help health care providers develop better programs to protect such young men. The study researchers, Dr. Carol Dawson-Rose, RN, PhD and Austin Nation, RN, MSN from the UCSF School of Nursing, Department of Community Health Systems will explain this study to you.

Research studies include only people who choose to take part. We want participants to take their time to make a decision about participating, and discuss your decision with your family or friends if they wish. If you have any questions you may ask the researchers.

You are being asked to take part in this study if you are a young men who has sex with men and has a history of substance use.

Why is this study being done?

The purpose of this study is to better understand the meaning of substance use for HIV-positive and HIV-negative young men who have sex with men. The study seeks to answer the question: What are your perceptions of the role substance use plays in acquiring HIV among young men who have sex with men?

This study is not financially supported from outside resources and will be financially supported through the personal funds of the co-PI.

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How many people will take part in this study?

About 10 people will take part in this study

.

What will happen if I take part in this study?

If you agree, the following procedures will occur:

- You will meet with the researcher for a private interview at a date, time and mutually agreeable location this is safe, private, and secure for both participant and interviewer. You will be asked to describe your experiences with substance use as a HIV-positive or HIV-negative young man who has sex with men. This interview will take no longer than 2 hours.

- A second interview may be necessary to clarify information from the first interview. The second interview will take no longer than 2 hours
- The researcher will make a sound recording of your conversation. After the interview, someone will type into a computer a transcription of what's on the tape and will remove any mention of names. Once the transcription has been reviewed and compared to the audio recording, the recording will be destroyed.
- **Study Location:** All these procedures will be done at a location that is **mutually** agreed upon between you and the researcher. The location will provide for privacy, comfort and safety for you and the researcher.

How long will I be in the study?

Participation in the study will take a total of no more than 4 hours over a period of one or two interviews.

Can I stop being in the study?

Yes. You can decide to stop at any time. Just tell the researcher right away that you wish to stop being in the study. Also, the study researcher may stop you from taking part in this study at any time if he believes it is in your best interest or if the study is stopped.

What side effects or risks can I expect from being in the study?

- Some of the interview questions may make you worried or upset. You are free to not answer any question. You are free to end the interview at any time.
- If you do not wish to continue an interview, you may request to reschedule at a later time.
- **Confidentiality:** Participation in research may involve a loss of privacy; however your records will be handled as confidentially as possible. Only the researchers working on the study will have access to your records. After the interview information has been transcribed from the audio recording and verified, the recording will be destroyed. Your name or other information that interviews you will not be used in any reports or publications that may result from this study.

Are there benefits to taking part in the study?

There will be no direct benefit to you from participating in this study. However, information that you provide may help health care professionals better understand the experiences of HIV-positive or HIV-negative young men who have sex with men who have experienced substance use.

What other choices do I have if I do not take part in this study?

You are free to choose not to participate in this study. If you decide not to take part in this study, there will be no penalty to you. You will not lose any of your regular benefits,

and you can still get your care from your institution the way you usually do.

Will information about me be kept private?

- We will do our best to make sure that the personal information gathered for this study is kept private. However, we do not guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used. If, during participation in this study, you report instances of child abuse or neglect, the researchers will report these events to the authorities as well as your contact information that you have provided. In addition if you report thoughts of self-harm, for your safety, the researchers may also take further action. Further explanation of these instances is given below:

- Suspected child abuse or neglect: If during the interview process you reveal information that suggests that a child has been abused or neglected by you or anyone else, the researcher is required to report this to Child Protective Services for further investigation.
- Suspected self-harm or suicidal thoughts: If during the interview process you reveal information that suggests that you have thoughts of hurting yourself or share thoughts of suicide, the researcher may call 911 and emergency personnel if he feels you are in immediate danger.

Organizations that may look at and/or copy your research records for research, quality assurance, and data analysis include: UCSF's Committee on Human Research.

What are the costs of taking part in this study?

You will not be charged for any of the study or procedures.

Will I be paid for taking part in this study?

In return for your time, effort and travel expenses you will be paid \$20.00 per interview for taking part in this study, the maximum payment amount will be \$40.00. You will be paid in cash, immediately following the completion of each interview.

What are my rights if I take part in this study?

Taking part in this study is your choice. You may choose either to take part or not to take part in the study. If you decide to take part in this study, you may leave the study at any time and will not lose any of your regular benefits, and you can still get your care from the institution the way that you usually do.

Who can answer my questions about the study?

You can talk to the researchers about any questions, concerns, or complaints, you have about this study. Contact the researchers Austin Nation at [REDACTED] or Dr. Carol Dawson-Rose at [REDACTED].

If you wish to ask questions about the study or your rights as a research participant to someone other than the researchers or if you wish to voice any problems or concerns you may have about the study, please call the Office of the Committee on Human Research at [REDACTED].

CONSENT

You have been given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You have the right to decline to be in this study, or to withdraw from it at any point without penalty or loss of benefits to which you are otherwise entitled.

If you wish to participate in this study, tell the researcher.

Appendix E: Informed Consent

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO INFORMATION SHEET TO PARTICIPATE IN A RESEARCH STUDY

The purpose of this study is to better understand substance use and HIV risk for young men. Having a better understanding of the role that substance use has in HIV risk will help health care providers develop better programs to protect such young men. The study researchers, Dr. Carol Dawson-Rose, RN, PhD and Austin Nation, RN, MSN from the UCSF School of Nursing, Department of Social and Behavioral Sciences will explain this study to you.

Research studies include only people who choose to take part. Please take your time to make your decision about participating, and you can discuss your decision with your family or friends if you wish. If you have any questions you may ask the researchers.

This study is not financially supported from outside resources and will be financially supported through the personal funds of the co-PI. The study will serve as the foundation for a larger study in the future.

How many people will take part in this study?

About 10 people will take part in this study

What will happen if I take part in this study?

If you agree, the following procedures will occur:

- You will meet with the researcher for a private interview at a date, time and mutually agreeable location this is safe, private and secure for both participant and interviewer. You will be asked to describe your experiences with the role that substance use has in HIV risk.
- This interview will take no longer than 2 hours. A second interview may be necessary to clarify information from the first interview. The second interview will take no longer than 2 hours.
- The researcher will make a sound recording of your conversation. After the interview, someone will type into a computer a transcription of what's on the tape and will remove any mention of names. Once the transcription has been reviewed and compared to the audio recording, the recording will be destroyed.

How long will I be in the study?

Participation in the study will take a total of no more than 4 hours; the first interview will not last longer than 2 hours and a second 2 hour interview may be necessary to clarify information from the first interview.

Can I stop being in the study?

Yes. You can decide to stop at any time. Just tell the researcher right away that you wish to stop being in the study. Also, the study researcher may stop you from taking part in this study at any time if he believes it is in your best interest or if the study is stopped.

What side effects or risks can I expect from being in the study?

Some of the interview questions may make you worried or upset. You are free to not answer any question. You are free to end the interview at any time.

If you do not wish to continue an interview, you may request to reschedule at a later time.

Confidentiality: Participation in research may involve a loss of privacy; however your records will be handled as confidentially as possible. Only the researchers working on the study will have access to your records. After the interview information has been transcribed from the audio recording and verified, the recording will be destroyed. Your name or other information that interviews you will not be used in any reports or publications that may result from this study.

Are there benefits to taking part in the study?

There will be no direct benefit to you from participating in this study. However, information that you provide may help health care professionals better understand the experiences of young men like yourself.

What other choices do I have if I do not take part in this study?

You are free to choose not to participate in this study. If you decide not to take part in this study, there will be no penalty to you. You will not lose any of your regular benefits, and you can still get your care from your institution the way you usually do.

Will information about me be kept private?

We will do our best to make sure that the personal information gathered for this study is kept private. Your contact information will be kept secure and destroyed after the second interview or 12 weeks.

If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

However, we do not guarantee total privacy, as required by law, if during this study you report instances of child abuse or neglect, thoughts of suicide or self-harm, or harm to others, the researcher may call 911 and emergency personnel if he feels you are in immediate danger.

Organizations that may look at and/or copy your research records for research, quality assurance, and data analysis include: UCSF's Committee on Human Research.

What are the costs of taking part in this study?

You will not be charged for any of the study or procedures.

Will I be paid for taking part in this study?

In return for your time, effort and travel expenses you will be paid \$20.00 per interview for taking part in this study, the maximum payment amount will be \$40.00. You will be paid in cash, immediately following the completion of each interview.

What are my rights if I take part in this study?

Taking part in this study is your choice. You may choose either to take part or not to take part in the study. If you decide to take part in this study, you may leave the study at any time and will not lose any of your regular benefits, and you can still get your care from the institution the way that you usually do.

Who can answer my questions about the study?

You can talk to the researchers about any questions, concerns, or complaints, you have about this study. Contact the researchers Austin Nation at [REDACTED] or Dr. Carol Dawson-Rose at [REDACTED]

If you wish to ask questions about the study or your rights as a research participant to someone other than the researchers or if you wish to voice any problems or concerns you may have about the study, please call the Office of the Committee on Human Research at [REDACTED]

Consent

You have been given a copy of this consent form to keep.

Participation in research is voluntary. You have the right to decline to be in this study, or to withdraw from it at any point without penalty or loss of benefits to which you are otherwise entitled.

If you wish to participate in this study, tell the researcher.

Signature (only if minor) _____

Appendix F: Demographic Sheet

Your contact information will be kept secure and destroyed after the second interview or 12 weeks.

1. Preferred Code Name (Pseudonym) : _____
2. Preferred Method of Contact for Second Interview _____
3. Zip Code in San Francisco _____
4. Age: _____
5. Age of initiation of sex: _____
6. Relationship Status: Single _____ Regular Partner _____ Casual Partner _____
7. Sexual Orientation _____
8. Level of Education:
 - a. Grade School
 - b. High School
 - c. Some College
 - d. College Graduate
9. Employment/Student Status (circle all that apply)
 - a. Full-time
 - b. Part-time
 - c. Looking for Job
 - d. Not looking for Job
 - e. Unemployed
 - f. Student
 - e. Other _____
10. What is your HIV status? ___HIV-positive ___HIV-negative
 If HIV-positive, what year did you find out your diagnosis? _____
11. Do you currently use drugs or drink alcohol (including beer or wine)? Yes No
 Drug of Choice _____

12. At what age did you have your first alcoholic drink or drug? _____

13. HIV-positive only:

Did you use drugs or drink alcohol prior to testing HIV-positive? Yes No

Appendix G: Interview Questions

Preamble:

Thank you for taking the time to meet with me and be interviewed. As we've previously discussed, the purpose of this study is to understand the experience of substance use for HIV-positive and HIV-negative young men who have sex with men. I'm not here to judge you; rather my goal is to learn from you, and what your experiences have been. So in order to do that, from time to time I'll be asking you to give me examples and explain in more detail what you mean so that I make sure that I understand. Does that make sense?

AIMS:

- 1) Understand the role that substance use plays in the lives of young MSM substance users.
- 2) Describe the perceived risks for acquiring HIV among young MSM substance users.
- 3) Explore the historical and social contextual experiences that have influenced young Black MSM substance users.

As some of your experiences may have been traumatic or distressing, recalling them may bring up some unpleasant emotions. If at any point you feel uncomfortable with what we are discussing, wish to take a break, or end the interview please let me know.

You may refuse to answer any of the questions. As this interview is supposed to be like a conversation, please feel free to talk about things that you think might be important, even if the question didn't ask about them specifically.

Every effort will be made to maintain your privacy, anonymity, and confidentiality of everything that we discuss here.

I may make a few notes during the interview to help guide the questions I will be asking you.

Do you have any questions for me before we begin?

OK. Let's get started.

Introductory questions:

- 1) I'd like to begin by getting to know you better. Tell me a bit about yourself.
- 2) How do you see yourself as a person? How would you describe yourself to someone else?

Intermediate questions:

- 3) Tell me about what it is like to be a young man who has sex with men?
- 4) Tell me the story of how you came to learn your HIV status?
 - What lead you to take the HIV test?
- 5) What ideas do you have about how you might have managed maintaining this HIV status?
- 6) Tell me about the role past substance use played in your life prior to testing for HIV?
- 7) How was your substance use once you found out your HIV-status?
 - Has there been any change in your substance use recently?
If HIV-positive - Has substance use played a role in how you deal with being HIV- positive?
- 8) How does substance use relate to your sexual behavior or sexual risk?
 - Has substance use changed the way you have sex?
 - Does it make you feel sexy and more sexual? If so, tell me more....
 - How has it changed your sexual behavior and sexual practices?
- 9) What role, if any, did substance use play in you acquiring HIV or any other STD?
- 10) Is there someone, someplace or a way that would have been best to communicate prevention messages to you?
- 11) Have you had any adverse childhood events (ACE), have they experienced sexual, physical, or emotional abuse?
- 12) Who is a part of your “family” and other social networks?
- 13) Have you experience problems in your life because of socioeconomics, stigma, racism, etc?

- 14) Do you have mental health or other health issues?
- 15) What are your words of wisdom or other things that would have helped you or other people your age to help them avoid becoming HIV-infected? (suggestions of peer prevention messages)
- To avoid risky sexual behavior?
 - To avoid using drug and alcohol use?
 - To avoid becoming a substance user?

Closing questions:

- 16) Are there questions that you thought I would have asked that I did not?
- 17) In light of everything we have spoken about, is there anything else you think is important to mention?
- 18) What questions do you have for me?

Prompts for interviewer:

- Tell me more about that?
- Can you give me an example of that?
- When that happened, what did you think or do?

Thank you very much for speaking to me today. Feel free to contact me, Dr. Carol Dawson-Rose, or the UCSF Committee on Human Subjects Research if you have any questions about the study. Let's set-up another date and time to meet for the next interview.

Publishing Agreement

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I hereby grant permission to the Graduate Division of the University of California, San Francisco to release copies of my thesis, dissertation, or manuscript to the Campus Library to provide access and preservation in whole or in part in perpetuity.

Author Signature



Date 5/27/16